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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Child Welfare Around the World

Speech and Hearing Impairments

Preschool Autistic Children

Deterrents to Prenatal Care

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Children—A Universal Concern 91
Dan Q. R. Mulock Houwer

Communicative Disorders in Children 98
Donald A. Harrington

Autistic Children in a Day Nursery 103
Margaret Lovatt

Public Welfare's Role in Day Care for Children . 109
Mrs. Randolph Guggenheimer

Deterrents to Prenatal Care 114
Howard B. Monahan and Esther C. Spencer

Children from 1912 to 2012 120

Book Notes 121

Here and There 122

Readers' Exchange 127

LEARNING ABOUT SOUND can be a surprise and delight to children such as these, to whom sound does not come naturally. Because of its effect in depriving children of speech stimulation, deafness or a severe hearing impairment can seriously impede a child's total development unless training in communication is begun early in life.

The importance of differential diagnosis in the treatment of communicative disorders is discussed in the article beginning on page 98.

Since becoming Secretary General of the International Union for Child Welfare in 1947, Dan Q. R. Mulock Houwer has visited child welfare organizations in nearly 30 countries. Previously he had worked closely with the Union while director of Zandbergen, an agency in Amersfoort, the Netherlands, offering residential treatment and foster family care to emotionally disturbed children, and before that as director of the National Bureau for Child Welfare at The Hague. Except for 3 years spent in a concentration camp during World War II, Mr. Mulock Houwer has been directing children's services since 1926 when he first became headmaster of an approved school for maladjusted children.

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Differences in resources and cultures in various parts of the world call for flexible approaches in helping . . .

CHILDREN— A UNIVERSAL CONCERN

DAN Q. R. MULOCK HOUWER
Secretary General, International Union for Child Welfare, Geneva

ON THE OCCASION of the 50th anniversary of the U.S. Children's Bureau, an enormous amount of material concerning conditions of American children in the past and today makes it possible to follow the development of child welfare in the United States, decade by decade, State by State, from a point of view of action by public and voluntary organizations, backed up by statistics, results of studies, and so on. On this basis, plans can be laid for the future of national child welfare. In respect to international child welfare not so much information is available and what there is is less reliable, more dispersed, and not easily brought together under one common denominator.

Some people look with rose-colored, others with dark, glasses at what material is available. I personally think that we should try to evaluate it with a cold, objective eye and a warm heart, even though we are aware that we do not possess very reliable statistics and that the situations on the various continents, even in the various countries within these continents, are very different as far as social conditions, health, education, and welfare are concerned. We must also be conscious of the fact that we are living in an epoch in which political and social patterns are changing quickly. Our goal, nevertheless, is to find out how we can influence developments in the international field in the right way for the world's children and thus for the world's future.

A well-known slogan says "history repeats itself." Maybe this is partly true when we compare our own child welfare history with present situations in the developing countries, for instance, in regard to the effects of urbanization and industrialization. However, today we also see new developments which have a character all their own. We are confronted with situations, philosophies, programing, and techniques which are different from those we know in the industrially developed West—the United States, Canada, Australia, New Zealand, and northern and western Europe. These differences represent, from several points of view, a challenge to which we must find not only the right, but also the convincing and successful answer.

Out of the world population of nearly 3 billion people, 65 percent are living in underdeveloped areas, in countries with the world's highest birth rates, highest child death rates, and also the lowest average incomes. The average annual expenditure per person in the United States, the United Kingdom, Western Germany, Sweden, and France merely on alcohol and tobacco is more than the average income per person in countries such as South Korea, Pakistan,

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Based on a talk given at the celebration of the Children's Bureau's 50th Anniversary, Washington, D.C., April 9, 1962. (See page 120.)

Crowded classrooms, such as this one in Egypt, are prevalent in the developing countries, where widespread enthusiasm for education is a part of the revolution of rising expectations.

the Congo, India, and Burma, to mention only a few examples.

In Western countries the average annual increase of population is 0.7 percent, while in underdeveloped areas, such as Central America, the Middle East, and Southeast Asia it is estimated to be 2 percent; and in South America, Turkey, and Malaya—3 percent. All countries have had considerable internal migration. Since 1900, the increase in urban population in Europe and the United States has been nearly 160 percent, whereas in Asia it has been estimated to be about 450 percent and in Africa 625 percent.

In the towns of the developed Western countries, there are usually opportunities for work for people who have migrated there and the increasing demands in the field of education and child welfare can more or less be met. The same can be said in regard to the Soviet Union. For the underdeveloped countries, however, in Asia, Africa, and Central America, the move to the cities means rising unemployment or substandard wages, the hideous sprawl of shanty towns, or no housing at all, an ever multiplying army of underfed families and children, and insufficient health, education, and child welfare facilities.

It is estimated that throughout the world at least 250 million people annually suffer clinical attacks of malaria and that about 2½ million of them die of the disease each year. Ten to 12 million people are stricken by leprosy, among whom a large proportion are children. While many developed countries have begun closing their tuberculosis sanatoriums for lack of patients, in underdeveloped countries tuberculosis kills approximately 5 million people per year. An estimated one-seventh of the world population, or 400 million people, suffer from trachoma, and where no adequate care is available, 10 million of them will become blind. More than 250 million people in the tropical areas are believed to be infected by filariasis, which produces elephantiasis. It is estimated that about 56 percent of the population in the underdeveloped countries are underfed and 20 percent are living on the borderline of starvation.

Since in these areas the child population constitutes 40 to 45 percent of the total population, such examples would seem to give a pretty gloomy picture of the situation of the world's children. But there are other brighter examples showing how situations improve. Japan, for example, has tackled her difficulties, which were aggravated by overpopulation and wartime devastation, with increasing success by improving agriculture, developing small and large industries, introducing a birth control program, and taking the lead among the pioneers in child welfare in the Far East. Another breathtaking development is to be found in Russia where in 1913 the infant mortality rate per 1,000 live births was 273; in 1940, 184; and today, 40.6. In 1917, the average expectation of life in Russia was the same as in India; in 1959, it reached 67 years—or twice as high. In India the infant mortality rate, which in 1922 was 550 per 1,000 live births, has been reduced to 127.

Today there is practically no tropical sickness which we cannot control thanks to the advances made in medical science. To give some striking examples: Ghana, through a medical program aided by WHO and UNICEF, expects to cure 42,000 cases out of 50,000 of leprosy within a very short time and to eradicate this disease in the near future. In Taiwan, a school health education program, in which children help children, has cured one million out of the 2 million school children of trachoma. In Indonesia, where there were 12 million sufferers from yaws, eradication of this disease can be foreseen within a few years.

The introduction of preventive methods, such as inoculations, clinical treatments, environmental sanitation programs, and destruction of disease carriers, has shown that it is not necessary for diseases like yaws, malaria, leprosy, trachoma, yellow fever, hookworm, and other infections to continue to enslave

the peoples of the underdeveloped areas as they have for centuries.

The main problem is to accelerate progress in acquiring the trained personnel and services needed. North America has one medical school for every 1.9 million people; Central America, Europe (including U.S.S.R.), and Oceania have one medical school for every 2.2 to 2.5 million people; Asia has one for every 8.3 million and Africa one for every 22.4 million. Oceania has one school of nursing for every 50,000 inhabitants; the United States, North and West Europe, one for every 150,000; India, one for every 2.2 million; Africa, one for every 5 million.

Not only can we reduce the high death rate in the underdeveloped countries, but we can also vanquish such other causes of misery as illiteracy and ignorance. Yet there is a new social problem which these countries must face—the "population explosion." Paradoxically, progress in the medical field, which has resulted in a decreasing death rate among children and an increasing average life span, has at the same time increased misery, since there has not been parallel economic progress. As a result there is not sufficient food; and the schools, though growing in number, cannot cope with the greater numbers of children. More teachers, school equipment, and vocational training, are urgently needed, as are more and more jobs.

In 1950, the situation regarding illiteracy was: North America, 3–4 percent; Europe (including the Soviet Union), 7–9 percent; Oceania, 10–11 percent; Central America, 40–42 percent; South America, 42–44 percent; Asia, 60–65 percent; Central Asia, 80–85 percent; Africa, 80–85 percent. Education, and more education, is the hearty cry in all the underdeveloped countries. In India, nearly half the children of school age now go to school, and in various urban areas of underdeveloped countries in West Africa, the percentage of children attending school has leaped up to 60–80 percent.

Rising Expectations

Many countries formerly under colonial rule have become independent since the Second World War and this process is continuing. But becoming free does not mean becoming free from hunger, disease, poverty, and ignorance, nor the ability to switch over quickly from colonial rule to a democratic system of government and living. Nevertheless, in the worldwide "revolution of rising expectations" people are claiming a higher level of living and adequate opportunities in labor, health, education, and welfare. Many stumbling blocks have to be removed, the biggest from a child welfare point of view is the economic one.

When establishing child welfare services, the economic structure of the country has to be taken into consideration, and these services must also be flexible. As approximatley 85 percent of the people in underdeveloped countries still live in rural areas, child welfare policy and programing cannot be identical with policy and programing in Western urbanized countries.

Essential to improved child welfare policy and programs in rural areas are such questions as how to obtain a better water supply, how to improve hygienic conditions, how to set up schools, how to improve nutrition by better cooking and better feeding habits, and how to teach mothers better child care and sound home economics, adjusted to their local situation. These and other needs may be met by community development projects, improved roads, mother and child health centers, low-cost houses, improved husbandry, and subsistence agriculture. Last but not least, it is essential to make village life more attractive in order to reduce migration. The drift to the towns in accelerating the breakdown of the traditional pattern of tribal and caste customs is undermining the natural social security of tribal and caste systems. Only in some cities is this loss made good by some sort of legally established social security system.

The child welfare problems in the towns are dominated by an ever increasing number of orphans, abandoned and neglected children, and juvenile delinquents. There are some institutions such as orphanages and homes for vagrant children or, in some countries, child welfare services patterned on those of the previously ruling powers, but inadequate in quantity and quality. The greatest need is prevention. At the moment, the number of children in institutions is estimated to be .02 per 1,000 to .08 per 1,000, about 40 million in all the underdeveloped countries of the world.

One of the main problems is the lack of trained personnel in all fields of child welfare. Even the developed countries need more social workers, but in relation to the shortage in underdeveloped areas, the West's need is microscopic. India, for example, with a population of 400 million, has fewer students in the schools of social work than Belgium and the Netherlands with 9 and 11 million, respectively. But in this regard, too, the picture is changing. There are schools for social work in Lebanon,

Ethiopia, Peru, Ghana, the Philippines, Turkey, Iran, and Sierra Leone.

I have in mind too the excellent work carried out by the Youth and Sport Commissariat in Morocco, in setting up educational programs for girls and women in rural areas and institutional care for juvenile delinquents; in Egypt, the multisocial service centers in rural areas, combining health, agriculture, and education; in the Ivory Coast, the small but dynamic social welfare centers located in towns; in Ghana, a very active mass education program; in Nigeria, an excellent social welfare scheme in Lagos; and in India, the increasing attention given to child welfare programs within the framework of the 5-year plans—in cooperation with the voluntary agency, the Indian Council for Child Welfare.

Different Approaches

In developed countries, especially in free democratic States in which legislation provides both for the freedom of the individual and the protection of the weak and underprivileged, we are no longer worried by hunger and disease. Our child welfare programs are family centered; the family is seen as the nuclear cell in society. Our main concern is how to strengthen family life, how to prevent the child from being placed outside his family, how to correct by care, reeducation, and specialized treatment. Instead of the army of orphans and half-orphans of the past, we have today a not inconsiderable army of children who are victims of lack of love, inadequate education, disharmonious family life, divorce of their parents, or insufficient care because both of their parents work. And we have an increasing number of juvenile delinquents.

In the Western developed countries, we work on the principle that there is a functional relationship between prevention of maladjustment and the care of the child who cannot stay at home for one or another reason. Our aim is to improve the quality and quantity of such preventive services as family social agencies, child guidance clinics, vocational guidance bureaus, leisure time organizations, special police brigades, probation services, and children's courts. More and more we try to specialize the care for children through casework, group work, individual and group therapy, training centers, residential treatment centers, aftercare, and followup.

Problems in the field of child welfare in underdeveloped areas do not have the same character. They are both simpler and more complex. They are simpler if you see them merely from the point of view of the necessity to improve nutrition, hygiene and medical care, to increase the number of mother and child health centers, crèches, kindergartens, playgrounds, schools, vocational training centers, institutions for orphans, abandoned and delinquent children, and the like. They are more complex in regard to approach.

The democratic approach, which in Western countries has a long history and in which all our child welfare principles are rooted, is in many of the underdeveloped countries blocked by the fact that democracy and Western philosophy are not compatible with the internal historical and political situation. The strongest representation of a democratic philosophy in child welfare in any underdeveloped country is to be found in India, but for many other underdeveloped countries, the collective approach has attraction. The tribal community cannot be compared with our small two-generation family, and our Western approach, methodology, and techniques are therefore not tailormade for this culture. The Western approach is based on the "I (child)— you (parent)" relationship, the tribal approach on the "I (child)—we (tribe)" relationship, and the collective approach on the "I (child)—we (community)" relationship. A midway approach is the "I (child)—you (child care worker)—we (community)" which you find in Israel in the kibbutzim.

What complicates the Western or democratic approach is the manifest or latent antagonistic attitude in many underdeveloped areas toward Western people and customs and, in general, toward the democratic way of life, a combination of a reaction against former colonial rule, and the effect of all kinds of propaganda associated with the color bar, capitalism, imperialism, colonialism, and so on. If social workers fail to take such reactions into account, they remain blind to reality.

It is impossible to indicate a uniform child welfare approach, policy, and programing for the developing countries as there are so many different kinds of needs in the different parts of Africa, Asia, and South Amerca. We are just beginning to recognize such differences and the various approaches indicated for adjusting modern knowledge, techniques, and skills to certain conceptions of community life.

Directions in the West

Affluent countries will certainly concentrate their attention more and more on their specific child welfare problems of which juvenile delinquency and gang behavior are the most widely known but do not,

in fact, constitute Problem Number One. Rather, Problem Number One is how to create a sound community spirit and life, and better training for citizenship. For curing our maladjusted and asocial youngsters, specialization is required. We shall always need child guidance clinics, treatment centers, and so on, but these do not eradicate maladjustment, juvenile delinquency, and gangsterism, just as malaria is not eradicated by excellent hospital care alone.

In order to give better services, two lines of development can be foreseen. The first is to invest more money in the services for preventive work and special care, especially in relation to family, school, job, leisure-time activities for youth, and the mass media of communication which have such a strong influence on our children and youth. In respect to these areas, material from the 1960 White House Conference on Children and Youth gives a rich source of suggestions as to what ought to be done.

In the Western developed countries, the functional relation between preventive work (care for the child at home) and child welfare services for the child who cannot stay in his own home (foster care and institutional care) will change increasingly, as the old formula of congregate institutions for deprived, maladjusted, or delinquent children changes in the direction of the cottage system. In countries where there is more differentiation in child welfare and where there is a better system of internal and external classification of institutions, the functional relation existing between foster care and institutional care will change too. One promising movement for preventive work may be found in what is called in Germany the "open door" homes—a very flexible, social pedagogical action for meeting, in a more constructive way, the youth on the street.

Another promising approach toward prevention of delinquency is to be found in the Dutch Ministry of Education's system of education and resocialization in short-term camps. These camps, which are only attended by youngsters who want to and are based on youth movement principles, are characterized by an excellent corrective, individualized school program and a way of living which trains for citizenship.

Other sunrays can be seen in the enormous amount of progress in reducing institutionalization of mildly and moderately mentally retarded children and young people. Thanks to improved and more adequate education and training programs, the majority of these youngsters not only can stay at home but can even find their place in the normal labor market. The more seriously handicapped can, for the most part, be maintained by "protected" workshops, clubs for their free time, and social pedagogical services to help them and assist their parents. It can be foreseen that organizations of parents of mentally retarded children will become stronger and stronger and will fight for these opportunities as they have done so successfully in the United States.

Another category of children for whom preventive services, in the form of day-care homes and day-care treatment centers, will be strengthened is that of the maladjusted children who cannot be satisfactorily helped by child guidance clinics, but for whom placement in a training school or residential treatment center is not desirable. In the last 15 years, various training schools and residential centers in developed countries of the West have been influenced by the work of such Americans as Bruno Bettelheim, Fritz Redl, Herschel Alt, Ernst Papanek, Gisela Konopka, Suzanne Schulze, and others, but it can be foreseen that a trend differing from the American conception will accelerate development based less on social work principles such as casework and group work, though advantage will be taken of these work techniques, and more on the psycho-

These two Peruvian brothers, who earn their living as water bearers in a Lima slum, illustrate the kind of problems which face child welfare efforts in many Latin American countries.

pedagogical and social pedagogical approach. One of the most beautiful realizations of this conception is the training center for specialized educators (psycho-pedagogues) in Montreal.

The total picture of institutional care shows an increasing weakening of the disciplinary (authoritarian) system, a decline of the progressive (advancing by degrees) system, and an increasing trend in the direction of the sociopedagogical (emphasis on the group and on collectivity), psycho-individual, and eclectic systems.

Foster family care will increase in European low-income countries as the standard of living rises, but it will decrease in economically developed countries because the increased affluence and problems of raising families in modern high-rise housing tend to decrease the availability of foster boarding homes.

Nevertheless, the trend toward finding a solution for maladjusted children in specialized foster family care will increase although it will remain limited and will mainly be used for the children and youngsters who for one or another reason are unsuited or less suited to residential care. One of the inspiring projects in this field is that of Prof. Hart de Ruyter at Groningen in the Netherlands. In regard to the criteria of placement, ideas are changing, particularly for this group of children. Ideas are less bound to casework principles than to the thought that for the key to each child's development, the right lock must be found.

It can be foreseen, however, that what will be most emphasized is the "link institution" between institutional care and foster care, the development of the group home, especially where there are special educational and treatment facilities in the community.

I believe that a second challenge will demand serious attention, and that is the problem posed by changing values in our Western world and the necessity for us, as adults, to review our own attitude, particularly in the fields of education and child welfare. We call the family one of the cornerstones of individual and social education, and, if there is any trouble with our youngsters, and with our adults too, we blame it mostly on their lack of love and security especially in the first years of life. While recognizing the value of this point of view, we surely should look more at the influence on total development of other periods of life and in this connection realize our failure to replace with a strong and inspiring value image what has today become a kind of "value vacuum."

If we do not find a solution for this, then our philosophy and democracy are at stake, for we are on the downward path of the hill of freedom when we claim too many rights without being sufficiently concerned about duties and obligations. No child welfare program can function adequately or develop into successful individual and social preventive work, supplemented by specialized care, if democracy is misused as a garden where the beautiful flowers of freedom can be picked without bothering about the responsibilities involved in keeping the soil of freedom and well-being fertile.

The Developing Countries

In the developing countries, the main fight will be in the economic field in order to improve agriculture and industry and raise the standard of living. Increasing attention will also be given to child welfare community development projects.

There will be a larger number of requests for projects to be assisted by the United Nations and its specialized agencies, such as the United Nations Bureau of Social Affairs, WHO, UNICEF, FAO, ILO, and UNESCO. One of the more important activities in child welfare is UNICEF's recently established program of assistance to social services for children.[1] More help is expected from nongovernmental international organizations, not only through material aid, but also in training at various levels, in cooperation with the United Nations specialized agencies, local governments, and voluntary groups. The training of top people is, however, hindered by the present small number of candidates with high school education, so that the most help will have to be given to training at the lower level.

Research will have to be extended to find out the best way of adjusting modern techniques to the lower income areas, to their family and community structure, both from the economic and from the social, religious, and political points of view. Much can be contributed by using the information gained from the experiences of the United States Peace Corps.

I wonder, too, whether there is not a source of manpower, neglected until now, in retired people who at one time worked in the field of child welfare, agriculture, or industry, from whose wisdom and knowledge we could profit. I know, from my own experience, how valuable these people are and the excellent job they could do if given a chance.

New aspects in child welfare policy will also arise in developing countries. We can foresee that the movement of youth brigades will increase, either on

the pattern of those in Yugoslavia and Poland, or with a character of their own in such countries as Ghana and the Congo.

In many underdeveloped areas, not much is done for the girls in need, but this situation will quickly alter as it has already, for example, in Egypt, Morocco, Ghana, Nigeria, and India.

The developed countries' nongovernmental organizations which have international programs could, and should, help more than they have until now to establish national councils of voluntary child welfare agencies, a practice advocated for many years by the International Union for Child Welfare. Such national councils can, in cooperation with the governments, play an important role in the planning and improvement of child welfare standards, policy, and programing. A good example is in India. In this way, the voluntary groups can encourage a democratic approach.

All international action to improve child welfare should be directed to giving the leading people in developing areas a chance to "do it themselves," in their own way, adapting child welfare principles to their own situation and style of living.

Although society in underdeveloped areas is mainly a "man's society," much depends, in the field of social services for families and children, on the cooperation of women. Help given to women through pilot projects in such simple things as environmental hygiene, home economics, child care, improved nutrition, sewing, weaving, spinning, dressmaking, toymaking, and the like, can be one of the most forceful contributions toward better child welfare in both rural and urban areas. In Africa, where many women are engaged in trade, the introduction of kindergartens near the markets could help the well-being of millions of children and mothers. The same applies to crèches, day-care centers, and simple playgrounds in the shanty towns of the low-income countries. The greatest success is to be expected from the "step by step" programs which start from the bottom and develop progressively.

The best training plan for the child welfare workers from underdeveloped countries does not seem to be to send them to the Western countries, as the training acquired there does not seem to stir up their imagination and ability, nor teach them the knowledge and skills they need for working in a country with limited resources and shortage of skilled manpower. The Western way of thinking and acting is based too much on the individualistic and psychological approach, to be of use in the underdeveloped areas which require a more social pedagogical approach.

Western training centers, however, should be used for people working with physically and mentally handicapped children.

The care for children outside their homes will develop along its own lines. Foster care in developing countries cannot be compared with the basic Western idea regarding placement techniques and criteria. It is to be expected that emphasis will be directed more toward improving the local customs in the upbringing of children by the members of the family or of the tribe.

Concerning institutional care, the psycho- and group-therapy approaches will have few chances of being adopted, because of lack of experts and the great difficulty in providing facilities for the education and care even of normal children.

In the developing countries, the old customs and traditions, even though still dominant, are wavering under urban influences and the effects of formal education, but this does not mean that there is a value vacuum as there seems to be in the West. New countries have their ideals and belief in the future. In this period of changing values, some political leaders may misuse the young people, who are disappointed that independence has not brought a speedy improvement in the standard of living by leading them toward aggressive Chauvinist ideals. However, many other leaders represent a much sounder image for the youngsters, as they serve their country and their people with dignity, self-discipline, and without aggression toward other countries.

I have here only touched lightly upon the problems that exist in the field of child welfare from an international point of view. Even so, I hope that I have indicated how fascinating this work is and especially what could and should be done to achieve greater cooperation between those working in child welfare in both developed and underdeveloped countries so that we may live up to the principles embodied in the United Nations Declaration of the Rights of the Child.[2]

[1] Pate, Maurice: Future directions of UNICEF. *Children*, September–October 1961.

[2] Declaration of the rights of the child. *Children*, March–April 1960.

Why early identification and treatment are important when there are . . .

COMMUNICATIVE DISORDERS IN CHILDREN

DONALD A. HARRINGTON

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Children's Bureau

COMMUNICATION is a process defined somewhat differently by the disciplines of engineering, sociology, physics, public speaking psychology, and others. No single definition is likely to suit all of these fields; essentially, *communication is a process of transferring meanings from one person to another.*[1]

In this article the term "communicative disorders," as used by speech pathologists and audiologists, refers to impairments in speech, hearing, or language.

How soon can a communicative disorder be recognized in a child? How soon shall something be done? What should be done? Who shall do it? A discussion of these questions requires an understanding of the normal development of communication.

Speech

Communication begins when the baby signals his arrival into the world. For a period of 3 or 4 weeks his crying, at first, is simply a reflex action and, to our ears, is undifferentiated. His parents cannot always tell whether it means he has hunger pangs or pants problems, but by the end of 3 months both baby and mother agree that certain kinds of cries are to have different meanings. By this time, he has developed a rudimentary monitoring system whereby both auditory and kinesthetic stimuli constitute feedback clues which are used to modify his vocalizations to express different meanings. At this stage too, the baby begins to repeat consonants and vowels in a random fashion, without any linguistic purpose. Most speech authorities refer to this as the beginning of the babbling stage. When the baby is about 6 months of age, this vocal play increases and inflectional patterns appear. Around the ninth month, he begins to repeat sounds in a more differentiated, less random, way. Repeated syllables become meaningful, such as "mama" and "bye-bye," etc. His vocal pattern reflects the fact that through listening he has been learning to mimic and echo what he hears. At 12 months his one word may stand for a whole sentence to the listener who understands the context.

Then the baby's rate of linguistic growth begins to spurt. The jargon he uses, although it is largely unintelligible, does not seem to be as random nor as meaningless as his early babbling. The mythical average child then begins to *talk* at one year, only if the definition of the word *talk* is not too rigorous.

Hearing

Hearing is necessary to this early speech development for if the child cannot hear he does not learn to mimic sounds and inflectional patterns, even though he may make a variety of sounds. If he cannot hear in the fullest sense of the word he does not learn that sounds are symbols. He is delayed in forming the concepts and verbalizations which mark a language system. His delay in language learning continues to

be a serious handicap throughout his life if his hearing impairment is severe.

The newborn's response to sound is a blink, or a startled reflex, or a movement of his body. Between 3 and 4 months, he may respond to loud sharp noises with a gross body reflex. At about this age, he tries to locate a gentle sound by turning his head toward it. By 6 months, he responds to the quiet sounds to which he has become conditioned. Between his first and second year, if he has normal hearing, he responds to his own name and may comply with a command or a direction. By the age of 2 years, he locates and identifies familiar sounds, and responds to commands. At this age the child's hearing can be tested with a pure tone audiometer in a clinical situation by using some of the more sophisticated methods of maintaining rapport. Research is still being conducted on the infant's response to sounds. The Johns Hopkins University has just finished a new color film which demonstrates a method of testing the infant's response to sounds. [See page 126.]

As the child develops, he is more and more able to respond to specific sounds and to reproduce those sounds. He copies the language which he hears about him both in its grammatical structure and in its phonetic aspects. He learns to monitor his own speech, gradually learning to make it conform to the speech he hears.

The hearing function, of course, includes more than an acuity for loudness. It includes the function of comprehension. The development of language depends upon a complex cortical activity, including the integration of stimuli received from all senses. Other sensory impairment, as well as a hearing impairment, such as the deprivation of visual, tactile, and olfactory stimuli, may affect language development adversely. These senses are important to the development of concepts.

Language

Normal language development begins when the child learns to modify his crying to get desirable responses from his environment. This crude symbol system is quite efficient considering the infant's limited needs and his limited environment. As a child becomes more independent—creeping, standing, and walking—he has to make a wider range of responses toward his environment and also he seeks more discriminate responses from others. His language-symbol system must grow rapidly in both verbal and nonverbal aspects to keep pace with his social achievements.

Props as well as techniques are sometimes needed in working with children with communicative problems. Here the speech therapist uses a truck to evoke a response from her patient.

Parents respond to the child's different noises in an increasingly precise way. These reactions help the child to become conscious that a language system exists. His vocal play is repeated by his parents and he soon learns to expect a pleasurable reaction from talking or other communicative actions. He becomes conditioned to specific auditory stimuli so that these stimuli become meaningful. Later these signals become generalized in their meaning and the child begins to build his language without having to be taught every single word. At 9 to 12 months the average child comprehends a great deal of what he hears. He relates symbols to objects, responds to commands, and understands questions. His own words do not have a sentence structure as yet, but by 3 years he uses language very well.

However, until cortical levels are fully developed physically, true conversational speech should not be expected. The child who has not developed normally in other respects should not be expected to be ready for speech at an early age.

This brief look at the development of communication applies to the mythical average child. Although individual variation is great, the sequence of development is fairly uniform. If the child cannot achieve a further level of development, his communication problem requires a thorough diagnostic evaluation

in order to determine the etiology, prognosis, and treatment.

Disorders

Communicative disorders can be considered under the main divisions of impairments of speech, hearing, and language. Speech impairments include defects in articulation, voice production, or fluency of speaking, such as stuttering. By far the most common defects are articulation errors in which sounds are omitted, or distorted, or substitutions are made. In the normal maturation of articulation, those sounds which are made with two lips and which are easily visible such as b, p, m, and w develop early and are least likely to be incorrectly used. Some of the back tongue sounds, for instance, the k, g, and h, may be heard first. The tongue-tip sounds such as t, d, and n develop later, and those which require fine motor coordination to produce friction noises such as the s, z, and th develop still later.

The blending of consonants such as the *bl* of *blue*, the *fr* of *free*, and the *st* of *stay* call for even more intricate muscle adjustments and therefore children may be able to sound the consonants correctly without being able to put them into blends. A child who has just a few sound errors, who substitutes one sound for another, omits a few sounds, or distorts some of them, generally makes these errors on the sounds which are latest in normal development. Connected speech is characterized by the blending of the sounds at the end of one word with the sounds at the beginning of the next word, thus making a phrase sound like one long complicated word. A child may have difficulty in understanding such a message, let alone reproducing its parts.

Although the child of 1 to 2 years is not expected to be clearly intelligible to everyone, a 3-year-old should be fairly intelligible and the 4- to 5-year-old should have good intelligibility. Children who have such serious articulation problems as to be very unintelligible are frequently categorized as having delayed speech. Such children are very likely to be delayed in language development too. Furthermore, they may be delayed in many other aspects of growth and development. Therefore, a careful evaluation of the child's growth and behavior is important in making a decision about the nature and severity of the communicative disorder.

The search for causes is particularly important in making a differential diagnosis of communication problems. For instance, if the child has a hearing loss of a conductive type, the prognosis and treatment are different than when the child has an impairment of the sensory neural type. In the latter case, the auditory stimulus may have been distorted when presented to the cortical level, not just diminished. Of course a hearing impairment at the cortical level in which the meaning is not comprehended at all is still a different problem. If the cause of a communication problem is a cleft palate, different services are needed than if the cause is brain damage which resulted in muscle incoordination, or in cortical dysfunction without motor involvement. Such causes as mental retardation, or emotional disturbance, or the influence of adverse environmental factors result in different kinds of communication problems which require different kinds of treatment.

Needs

What are some of the needs of the child with a communicative disorder? Specific needs for each child will become evident as he is studied, but there are, however, some basic needs which can guide professional personnel in applying their knowledge of their own field to that of communicative disorders.

First, the most pressing need for the child with such a problem is for the problem to be identified and evaluated properly. It is not enough for a speech therapist to state that a speech problem exists, or for some other professional person to guess that the child will "grow out of it." For example, take one of the speech defects which is spoken of as a *simple* lisp. If this defect is treated as a problem in faulty learning, certain habit breaking and habit forming techniques might be recommended as therapeutic. But if the child who lisps has a mother or father who also lisps, then certainly the defect must be evaluated differently. Perhaps the child lisps only under emotional strain during which time other behavioral patterns also regress toward an infantile pattern. If a child has a severe malocclusion along with tongue thrusting habits, the lisp must be evaluated in a different category than *simple*. Clearly, the child with a lisp needs the benefit of services from disciplines which deal with both physical conditions and behavioral relationships.

Early identification of a child with a potential communication problem is not always possible, but there are some indicators. For example, a child who has a cleft palate will invariably need special speech help. Children with sensory or motor dysfunctions at birth are very likely to need help even though not all physical conditions affect the speech and hearing mechanism directly. Other examples

of children whose communication problems need to be evaluated carefully are those who appear to be mentally retarded, or emotionally disturbed, or whose environment may be lacking in the kinds of conditions which stimulate speech.

Other indicators that a child might eventually develop a speech problem may not be definite signs but nevertheless deserve attention. For instance, if the infant exhibits difficulty in nursing, the motor and sensory development of the oral mechanism may be at fault. Speech development depends upon the proper development of other activities too, such as biting, chewing, bubbling, and sipping. All of these activities occur within the first year. Failure of a child to respond to noises and voices may suggest a hearing impairment either in receiving sounds or in reacting to sound stimuli. If a child's vocalizations do not develop through the stage of playful babbling to a stage of inflectional changes, this too may suggest a hearing problem. If he cannot imitate sounds, does not comprehend, or cannot produce meaningful sounds, he is not *going* to have a speech impairment: he already has one. The first need then is that the communicative disorder should be identified and evaluated early so that the family can provide the appropriate services and training at the time when the child is ready.

Stimulation and Motivation

The second need of the child with a communication problem is to be stimulated. If he has a loss of auditory acuity, he may need a hearing aid. Visual stimulation can help him get the meanings of what others are trying to convey. If he has a loss of visual abilities, he needs special attention, for vision helps to develop the language system of symbols. He needs kinesthetic stimulation so that his oral structure becomes sensitive to the positions of the sounds produced. Any sensory impairment can affect the development of language concepts. Therefore, the child needs additional clues to reinforce those that he does receive.

He will need the stimulation that comes from parental responses to his noises. This encourages the development of an awareness that sounds can become symbols. The child needs to have his parents engage in vocal play with him: not to have them engage in baby talk, but rather to encourage him to make whatever noises he can make. It seems like a fairly simple thing for a parent to talk with his child, and it is, providing the child talks back. But even when the child does not verbalize, it is important for his parents to continue to talk to him. Speech stimulation can be enjoyable if it is made interesting with rhymes, jingles, songs, and word games.

The child's third need is to be provided with motivation. The strongest source of motivation is success.

As a first step in assuring success, parents should accept, reinforce, and reward speech attempts. On the other hand, they should not be so "accepting" that the child continues to use distortions which he could overcome. Since the child must feel that he is succeeding in communication, it is important to reduce goals to a realistic level. Phonetic precision is not a necessity. Speech which is too difficult for the child should not be expected. This kind of stimulation may lead to frustration and withdrawal: it does not promote learning. Acceptance of some phonetic deviation is necessary in order to give the child the kind of permissive environment in which he can learn. This creation of a feeling of belonging and security is an important first step in any therapy program.

The second step to success in learning is to help the child develop an awareness of differences. He should be taught the meanings of different sounds, but training in meanings should not be limited to acoustic differences. The differences in size, shape, texture, and color are important learning steps, especially to a child with a language difficulty.

The third step to success in learning is to help the child in using whatever speech he has. Situations should be set up to stimulate the child to use whatever speech he *can* in meaningful communicative attempts, not just in practices and drills. Such opportunities for him to succeed must recur regularly.

A fourth step to success is to try to reduce psychological barriers to the child's development which stem from frustration, bewilderment, anger, and hostility.

All of these steps can be met to some extent by the child's parents, and all of them are the proper concern of many different professional workers.

Parents, of course, need encouragement and counseling. They need information about their child's physical and emotional status, and his potentialities for overcoming his problem. They need someone to talk to who will take time to sort out their unreasonable fears from their reasonable anxieties. They need instruction which emphasizes the significance of other aspects of growth and development to the process of communication.

Children with voice disorders and stuttering have different specific needs from those who have articulation problems, but the principles discussed are equally significant to all communicative disorders.

The child with a hearing impairment especially needs stimulation by auditory, visual, and kinesthetic means. If the impairment could be removed, such a child would be free to learn. The responsibility, then, to overcome this impairment seems crucial. Above all, the child's difficulty must be discovered early in his life. Otologists believe that from 50 percent to 80 percent of impairments are of the kind which can be reversed or modified by early medical treatment. If medical care does not eliminate the hearing problem, the child may need a hearing aid. He will need instruction in recognizing speech visually by watching lip and other facial movements. He will need special instruction, if he has a severe hearing loss, to learn to monitor his own speech by kinesthetic and other clues.

Fulfilling the needs of a child with a language problem is difficult if the problem stems from a specific impairment in the language centers of the brain.[2] The child with such a problem needs a special training program; those planned for the mentally retarded, the emotionally disturbed, or the deaf are not adequate. A careful differential diagnosis must be made to avoid providing the child with inappropriate learning experiences. If, in addition to the specific language impairment, the child has other handicaps, then the program planned for him will have to be a compromise based upon an evaluation of his assets and potentialities.

In summary, I should like to reiterate the importance of early identification of the child with a communicative disorder and early evaluation of his problem. I should also like to stress the importance of stimulation aimed at overcoming sensory deprivation, and at improving the environmental factors which influence speech development; and of motivating the child toward success through the adoption of an accepting attitude toward him, helping him to develop an awareness of differences, encouraging him to say what he can in meaningful situations, and reducing psychological barriers to growth as far as possible.

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[1] Hochbaum, Godfrey M.: Modern theories of communication. *Children,* January–February 1960.

[2] Hardy, William G.; Pauls, Miriam D.: Atypical children with communicative disorders. *Children,* January–February 1959.

THE MYTH OF PREVENTION

Part of our problem in effectively serving and hence reincorporating the dissident 15 percent [of youth] in the past has been the illusion that by working with the most domesticated conforming easy-to-reach, the number of less conforming hard-to-reach would somehow diminish. This is the myth of prevention which mistakenly applies a concept suitable to public health to social welfare where it is wholly inapplicable. You can inoculate a healthy man against smallpox and predict accurately that he won't get the disease. You've saved him and yourself a hard time. Unfortunately, nobody can tell us what you can do with a healthy young child that will enable you to accurately predict that as a consequence of your action that child will not join the exiled as an adolescent. . . . I submit that to address ourselves to a problem, we must name it and work with it. In the present instance it is the problem of alienated youth. To develop a social strategy for the solution of this problem, there must be an analysis of its social, cultural, economic, and psychological roots. . . . Such a strategy must be designed to counteract the forces of racial, social, psychological, and economic discrimination that push young people out of the aspiration of the larger society.

Bertram M. Beck to the 1961 forum of the National Conference on Social Welfare.

A Canadian experiment in treatment of . . .

AUTISTIC CHILDREN IN A DAY NURSERY

MARGARET LOVATT

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A RESEARCH STUDY carried out from 1953–55 at the Hospital for Sick Children in Toronto, over 200 children from the Toronto area were found to be suffering from some form of childhood schizophrenia. Moreover, there was reason to believe that the community contained many more schizophrenic children. No treatment facilities for such children were available.

A large number of the known schizophrenic children were of preschool age and were described as "autistic" because of their isolation and withdrawal from contact with people. Unresponsive even to their own parents, they seemed to live in a dream world of their own, unrelated to reality. They appeared mentally retarded, and most of them lacked speech. They were unable to play. Our child guidance clinics were reluctant to serve such children since experience had shown that play therapy sessions, even when tried over a long period of time with such children, had produced little constructive results.

Authorities had indicated that if a schizophrenic child had not developed speech by the age of 5 or 6 years, the possibility of his improvement was slight.[1] An attempt to help these children in the early preschool years before their patterns of behavior and the family relationship and interaction patterns had become fixed, therefore, seemed urgent. It was urged that the community set up a pilot research and treatment service for them.

About the same time the West End Creche—a day nursery which provides a modern nursery program for normal children and specialized care for a few handicapped and disturbed children—was eager to provide a special service and research project based on a significant community need. Therefore the director of the Canadian Mental Health Association proposed that the crèche establish the much-needed day treatment center for preschool autistic children. In the center these children would have the benefits of a nursery school environment, the help of the trained nursery staff long experienced in working with preschool children, and the opportunity to be among normal children who would provide both stimulation and an example for them.

The crèche's psychiatric advisors made it clear that serving autistic children would be a long-term, demanding, and possibly unrewarding project; that there was little in the way of precedent to follow, and little in the way of success to be expected, for methods of treatment tried elsewhere had not produced any marked degree of success. Nevertheless, the agency accepted the assignment.

We recognized from the first that we could not "cure" these children. Our goal was to find out whether we could be of help to them, and if so, then in what way and to what degree. Could they be helped to experience at least some of the normal

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Based on a paper presented at the 1961 meeting of the National Conference on Social Welfare.

satisfactions of life and become in any real way participating members of their families, schools, and communities?

Dr. R. W. Keeler, who had conducted the hospital research, established the new treatment center within the crèche in 1956 with the advisory assistance of members of the Department of Psychiatry of the University of Toronto, and other clinical psychiatrists. Dr. Milada Havelkova took over from Dr. Keeler as medical director later that year.

At the end of the 5-year experimental period, the psychiatric advisors urged the center to continue, and a Provincial-Federal mental health grant was secured. This is supplemented by the United Community Fund, donations, and parents' fees.

The center provides care for 10 children, 5 children in the morning and 5 in the afternoon, each child attending 4 days a week. Because of the nature and severity of the illness, treatment for most of the children needs to be continued for at least 2 years. The age range at the time of admission corresponds with that of the nursery school children—3 or 4 years—so that if the children progress they are ready for kindergarten or first grade when they leave the center.

Staff Roles

The psychiatrist, who spends half of each day at the center, directs the total treatment program. This is organized around the usual staff team. However, the roles of the staff members have been somewhat changed.

The direct work with the children is done by the nursery teacher-therapists under the supervision of the psychiatrist, who observes the children regularly and holds a weekly consultation with each teacher. Each child has his own individual teacher-therapist for the 2 hours he attends the center each day, as well as his own playroom.

At least once a week the psychiatrist meets with the caseworker, who works with the parents. The psychiatrist also has periodic interviews with the parents, held jointly with the caseworker, to discuss the child's progress.

The caseworker holds weekly case consultations with each teacher. Two staff conferences are held each week—one for case discussion, and the second for more general purposes such as the discussion of methods, staff education, research, or planning. Neurological, psychological, speech, and some research services are secured when needed from the various health services in the community.

Our recognition that we cannot "cure" these children, is based on the belief that there is a biological factor involved in the illness, and that environmental factors only alter and possibly intensify the expression of the disease. The possibilities of successful treatment, therefore, seem to vary with the relative degree of biological and environmental involvements.

For instance, although treatment may help a child to get along quite well in the community, his personal relationships with people will probably remain restricted. Perhaps for tomorrow's children biochemical or other research will provide an answer to the biological problem and a means of preventing schizophrenia, or at least of controlling it. Meanwhile, the sick children of today must be given every chance to improve through experimental treatment, no matter how costly.

Two primary features of the center which, as far as I know, had not previously been used in treating such children are: (1) its setting in a nursery for normal children where the very gradual integration of the ill child into the normal group can be used as a treatment tool and in some instances as a means of motivating the child toward growth; and (2) the one-to-one relationship between the child and the teacher-therapist. The need for this one-to-one relationship in therapy seems to us implicit in the nature of the illness and the age of the children.

The Children

The children's symptoms are numerous and varied, some the opposite of others. For example, 4-year-old George was aggressive, hyperactive, and an expert at getting into difficulties. He would unscrew any electrical fixture in sight, turn on every tap he saw, and at home he would scale his backyard fence and wander off to a dangerous four-lane highway. Raymond, also 4, was an expert at evading supervision and, before coming to the center, had been given hospital treatment several times, after eating glass, drinking a bottle of tranquilizer, and darting into traffic. Rita used to inflict self-injury. Barbara bit, scratched, and kicked others. Mary, age 3, used to sit in a corner at home for an hour or more, her eyes shut tight, rocking back and forth. Attempts to contact her produced only screams and a deeper withdrawal. These are all symptoms which are prevalent among autistic children. Severe anxiety, emotional outbursts with no apparent cause, extreme negativism, and abnormal fears are common.

Although some of the children are of superior intelligence, all are immature, functioning often far

below their chronological age. A 3-year-old at admission may appear to be at an 18-month level in most functions. On the other hand, in one or more areas he may be more advanced than the average normal child. Jean, for instance, at 3 could pick up a complicated tune at one hearing, but in all else she was below a 2-year level.

These children are "flat" emotionally and do not feel affection for people, even their own parents. Their language and tears are often inappropriate. They relate better to objects than to people, and often carry around an object, perhaps a little box or a bottle, as a sort of emotional prop. Most of them either have not developed speech or do not use it to communicate with others though they may parrot phrases such as television commercials, in a meaningless way. Their play is compulsive or aimless, a mere handling of things, and seems to give them little pleasure. If left to themselves, some children may spend hours just sifting sand or bits of paper through their fingers.

Such symptoms indicated to us the autistic child's need of individual attention. Certainly in the beginning of treatment the child would not be able to make use of the group, nor would the group be able to tolerate his behavior.

As experience in treatment was gained, it became apparent that there were parallels between the treatment and educational needs of the child handicapped by infantile autism and children handicapped by physical conditions or sensory deprivation such as blindness or deafness. Through long-term training each must be helped to understand and accept the limitations which his handicap imposes, and to develop what capacities for normal living he has. Each must be helped to develop an ability to relate to and interact with his environment in a realistic and socially acceptable way.

For instance, some children who are partially isolated from their environment by congenital deafness can be taught in special schools not only to lipread but to develop speech and so become able to communicate with others. Also some children handicapped by congenital blindness, through a persistent long-term program of stimulation and special training can develop a keen awareness of their environment and take a real part in the life around them. Yet the limitations imposed by the handicaps of these children remain very real. Similarly through the development of a dependent trusting relationship and a long-term educational program, the teacher-therapist in our center tries to lead the autistic child into a greater awareness and understanding of his environment (personal and otherwise), to help him accept the limitations imposed by his illness, and through persistent repetitive training and support, to help him learn how to cope with his environment in a more realistic and socially acceptable way.

Beginning Treatment

When the child first comes to the center, the mother stays in the playroom with him and the teacher-therapist until he feels comfortable about separation. The therapist begins with a very permissive program, feeling her way, following the child's lead, testing out his responses, and adapting her methods to his particular and changing needs—trying to reduce his anxiety with acceptance and reassurance. She uses stimulation to draw him out from his haven of withdrawal, trying to get through to him through the use of whatever objects seem to give him at least some small satisfaction and to focus his attention for at least a moment or two.

The teacher often begins with mechanical objects, for which these youngsters usually have an obsessive fascination, such as anything with wheels—a truck, an eggbeater, rings, or bottle tops. Instead of playing with these as would a normal child, the sick child usually just spins them around or pushes them back and forth endlessly. Through using these objects with him, the teacher tries to rouse him into an awareness of herself, and then to some interest in other playthings and activities. For instance, the teacher might take a truck whose wheels the child is spinning, pile blocks in it and get him to dump them out; or get him to mix soap bubbles in a bowl with his eggbeater, encouraging him to accept a few simple directions. All the while the teacher helps the child to examine and experiment with each new object, to gain at least some slight satisfaction from it, and to learn something of how it can be used.

By keeping the child in his own small playroom in this early period, the distractions are reduced and the teacher is better able to hold his attention on herself and what they are doing together, and thus to keep him from withdrawing into his inner world. Gradually as the child becomes aware of his teacher, and as he develops some sense of confidence in her, more structure can be developed in the program activities and a few more limits set. Generally these youngsters, because of their anxiety and disorganization, are more comfortable and make better progress in a fairly structured program. They need the firm support which routine and structure impose, but

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these must be planned to meet each child's individual needs.

Throughout the child's attendance at the center the teacher continues the patient, oft-repeated explanation of things which arouse his anxiety, or of concepts which he finds difficult to grasp although they may be grasped quickly by a normal child. The schizophrenic child, for instance, finds great difficulty in distinguishing between the characteristics of inanimate objects and people. It takes time and repeated explanation for him to learn that it hurts a child if you kick him but it does not hurt a ball. Because concepts of space and time are difficult for him, he may try to squeeze himself into a tiny box and fail to understand why things which are to happen in an hour do not happen right now.

When the therapist has been able to establish some degree of relationship with the child so that he trusts and depends on her, she begins to lead him into a wider environment and among other people. He begins to move about the nursery building and playground, but under close supervision. If not closely supervised, the child without a sense of danger might walk heedlessly into moving swings. Another child may be so fearful of everything that for weeks he will venture onto a swing or go down a slide only if he is held firmly on his teacher's knee. Gradually he will find enough courage to go by himself.

In the Nursery School

As the child develops an ability to use his therapist's help, to accept some limits and direction, he may begin to visit in one of the normal nursery playrooms for a few minutes—at first perhaps while it is empty and later while a few children are there, but always with his nursery therapist close at hand for support. As he begins to tolerate or respond to this experience, the visits are lengthened and increased in variety. At first he may appear to ignore people who see him and greet him; he may "look right through them." If given free rein he may walk into a playroom, brush from a table whatever the other children are playing with, pile up a lot of toys and knock them down, circle around the room and leave, having looked at no one, child or adult.

When he is being introduced into the nursery school the therapist tells and shows him what is expected of the children there—the basic requirements of the playroom—and he is helped to meet these expectations as far as possible. Naturally there is great flexibility in the demands made on him, but the length of time he visits in the nursery playroom each day is gauged by his ability to conform at least to some extent to its basic requirements. Gradually he begins to "see" the children, to watch them, to begin to imitate them.

Play usually continues for a long time to be of a parallel type—the autistic child copying the other children rather than joining them in their activities—but some of the sick children (though not all) learn very gradually to take part in group activities, such as the music or story circle, although their performance may be erratic. During this integration in the normal nursery, the ill child has an opportunity for practice not only in using play materials and equipment but also in the difficult field of personal relationship. He can learn some of the social skills which the normal child learns, but for him the process of learning is much slower, and his hold on the skill much less sure.

In our nursery's experience the relationship between these children and the normal children has in no instance become very close as is often true of two normal children. However, some of the autistic children have gradually become able to interact with other children, to cooperate in play or in a chore on a more or less surface level, and to gain real enjoyment from the joint activities.

We have frequently been asked how the normal children react to the autistic children, and whether they are affected by the latter's unusual behavior. In order to maintain the "normalcy" of the group (for the sake of both the normal and sick children) we early established a policy allowing no more than one autistic child into any nursery group. Moreover, if the sick child's behavior becomes seriously disruptive, his therapist will take him out of the group to some individual activity. In these circumstances we have not found the normal children adversely affected by the behavior of the ill children. They do observe the strange behavior, and occasionally a child may even consciously imitate it once or twice, but finding therein little satisfaction he soon reverts to his own normal pattern.

The normal children do not show resentment when limits are sometimes stretched a bit for the sick children. In fact they are usually pleased to be helpful to them. While scarcely a day occurs without at least one parent of a normal child observing in the nursery school, we have never had a protest or expression of real anxiety about the influences of the ill children.

Throughout the period of integration into the nursery school, the therapist-teacher continues to

work individually with the child for part of each session, very often alone with him in his own small playroom. She continues to help him use his relationship with her to reduce his anxiety and fears, increase his skills, build his self-confidence, develop his speech, and adapt himself to normal social demands.

If the child continues to make progress in fitting into the nursery group, then the therapist begins to refer him to the nursery group teacher for direction and help. If he accepts this, then the new relationship is gradually built up and more and more responsibility for working with him is turned over to the group teacher, and the therapist gradually withdraws. This process takes many months.

Some of the sick children who achieved integration in the nursery school have been ready at the age of 5, others at 6, to test their new-found selves in the more demanding setting of the public school kindergarten. Before the child enters kindergarten, the center seeks the cooperation of the school, interpreting the child's special needs, and offering consultation from its psychiatric director. After the children leave the nursery, we continue our contact with them, their families, and schools for followup study.

All the children who started kindergarten after treatment have so far managed to continue at school, although in some instances despite considerable adjustment difficulty. Four of our first "graduates" are now in the second and third grades and are doing remarkably well. Since they progressed steadily after the difficulties of initial adjustment in kindergarten and grade one, it is hoped that the children now in their first and second years at school will also progress in the educational program. It is, of course, too early and too uncertain to make predictions.

Diagnostic Observation

During the past 4 years, the center has also provided a diagnostic observation service. We are now admitting two children each month for observation and have a long waiting list. Autistic symptoms in preschool children may be related to any one of a variety of conditions—childhood schizophrenia, brain damage, visual or hearing impairment, mental defects, or environmental emotional disturbances, or a combination of these. It is important that the causal condition of the autistic behavior be identified at an early age since plans for treatment vary with the basic condition.

Differential diagnosis is sometimes extremely difficult. Psychological tests for such children are of little value because of the child's inability to cooperate in the tests. A history secured from parents often provides baffling or contradictory diagnostic data; and often an examination of a preschool autistic child in the psychiatrist's office may prove quite as inconclusive.

In cases where the diagnostic picture is confused, the child may be referred to the center for a 4-week observation. He attends for 2 hours a day and is cared for by an individual teacher, his program being similar to that of a child in treatment. Some of the values of this type of observation are its length, the opportunity it provides for observing the child in the company of normal children as well as alone, and the long experience of the nursery staff in working with both normal and disturbed preschool children.

After the nursery's psychiatrist observes the child several times and the caseworker has 6 to 8 interviews with the parents, an evaluation is made of the child's ability to respond to people, to react appropriately to his environment, and to benefit from teaching. A conference is held with the referring psychiatrist or agency and a decision is made regarding diagnosis and possible plans for treatment or handling the child. These possibilities are then discussed with the parents and help given to them in planning for the child's care and development. Referrals are made to appropriate services.

The Parents

If the parents can achieve a realistic picture of the child's handicap and capacities, they may be able to prevent the development of further symptoms by reducing their expectations of him.

Much has been written about the "typical" personality structure of parents of schizophrenic, autistic children. Descriptive terms such as "cool," "aloof," "over-anxious," "rigid," "unsocial," and so on, have been used. It has been said that these parental characteristics result in inadequate parent-child relationships and thereby contribute largely to the development of the disease. More recently this theory has been strongly questioned, and it is becoming more generally accepted that the role of environment in the child's illness cannot be so definitely defined. In our experience, there have been parents of autistic children who have not fitted neatly into the classical picture and who have established good relationships with their other children.

Parents are deeply affected by the painful experience they suffer as they gradually become aware that

their child is mentally ill. If there is an inadequate parent-child relationship, this traumatic experience probably plays some role in its development. Even in the ill child's early infancy, his parents may feel puzzled and chilled by the child's strange lack of interest in them. As this continues, they feel deeply hurt and rejected.

In infancy and early childhood, schizophrenic children exhibit such problems as severe feeding difficulties, reversal of sleep patterns, rocking, twirling, or headbanging, withdrawal, or bursts of screaming. At times the child may be extremely negativistic. Parents may find themselves almost helpless in dealing with such behavior. As they fail to reach through to their child, they are overwhelmed by feelings of guilt and failure.

One of the primary needs of the parents, following the shock of the diagnosis, is help in accepting the reality of the child's mental illness and the inevitable readjustment that this requires in their family life and their outlook for the future. They need and want to understand the illness, its development, and its effects. What are the child's limitations? What of his future? How can they build a helpful relationship with him? They also need help in recognizing and expressing their feelings, especially toward their child and toward themselves. If they can come to understand and accept the child's limitations and adjust to a realistic level their standards for the child, and for themselves in dealing with him, then they can regain a sense of self-worth and the necessary control of their situation. The caseworker can be of real help in meeting these needs.

The caseworker may also help the parents in gaining some perspective on the often conflicting needs of the ill child and other members of the family. Sometimes where these conflicts are severe and cannot be reconciled, where treatment has not brought significant development and the prognosis is poor, the caseworker can help the parents think through the possibility of institutional care. The fact that treatment has been tried may make it easier for them to reconcile themselves to the necessity of institutional placement. In some instances the parents of ill children are themselves suffering from severe disturbances which are unlikely to respond to casework treatment. The caseworker can, however, support them in strengthening their defenses.

Throughout the child's treatment, the caseworker keeps closely in touch with the child's home experience, and the parents are similarly kept close to his experience in the nursery.

The Meaning

The role which mental illness plays in crippling and destroying our human resources has long been spelled out plainly. In Canada almost half of all the hospital beds are occupied by patients who are mentally ill,[2] and similar statistics, I believe, exist in the United States. What this means in human suffering we cannot conceive of, nor of what it represents in loss of manpower and in costs of care.

The problem is of such magnitude that it can only be fought with a concerted nationwide effort. This experimental demonstration service in a day nursery setting described here is on a very small scale, but joined to other numerous projects developing across the continent, it may prove to be of some significance in the general attack. Certainly to a number of our children it has given the chance to enjoy their childhood, and may mean for their future a sense of personal worth and a life of purpose.

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[1] Kanner, Leo; Eisenberg, Leon: Notes on the followup studies of autistic children. *In* Psychopathology of childhood. Paul H. Hoch and Joseph Zubin, eds. Grune & Stratton, New York, 1955.

[2] Encyclopedia Canadiana 1956: Mental health. The Grolier Society, Ottawa, Canada.

. . . The cause of children must always triumph ultimately. New standards of what constitutes scientific care and new knowledge as to what are the social needs of children will develop. The important thing is that we should be "on our way" toward adequately meeting their needs. Perhaps you may ask, "Does the road lead uphill all the way?" And I must answer, "Yes, to the very end."

Grace Abbott, past chief of the Children's Bureau, in a commencement address at the New Jersey College for Women, June 1934.

PUBLIC WELFARE'S ROLE IN DAY CARE FOR CHILDREN

MRS. RANDOLPH GUGGENHEIMER

President, National Committee for the Day Care of Children

SINCE a major purpose of a public welfare agency is the strengthening of family life, programs for the care of young children who cannot be properly cared for in their homes during the day must be high on the list of priorities.

Granted, a young child should spend much of his time during the day with his mother. In fact, the National Committee for the Day Care of Children is trying to make this possible for more children by urging realistic grants in aid to dependent children, by encouraging homemaker services and the development of more family casework agencies to help stem the appalling tide of family breakdown, by persuading industry to offer part-time jobs and selective hours for mothers of school-age children, and by convincing mothers of young children to delay entering the labor field whenever this seems feasible.

Day care away from home is not desirable for all children any more than foster care is. It is a service for those who need it—and for many children it offers far more than their homes ever could. The tragedy is that it is not available for large numbers who *do* need it—that it is too often misunderstood, badly financed, and operated without regard for the terrifying dangers of poor standards.

The kind of day-care program for which public agencies must accept more responsibility is a program with a careful intake policy that accepts children because this is the soundest plan that can be made for them, and that is able to provide expert help in working with the family to remedy the situation that made day care necessary.

Based on a paper presented at the 1961 National Biennial Round Table Conference of the American Public Welfare Association, Chicago.

Good day-care programs incorporate the best health and educational standards applicable to the age group served. For example, they provide family day care (care of individual children in a daytime foster family) for children under 3 as well as for children over 3 for whom the long day in a group situation is not desirable. Family day-care services lean heavily for their standards on standards for full-time foster family care.

A good day-care program also provides centers for the care of children in groups. A day-care center is not a nursery school, or a group work or recreation service, although if established for preschool children it may incorporate the kinds of programs that are present in good nursery schools, or, if for school-age children, the kind of skills that are used in group-work services. However, for children who are away from home most of the day there must be additional services to compensate for the lack of home and parental contact. In other words, there is some element of need present in the family of the child for whom day care is indicated. Many of these children have personal problems and many face home situations that must be taken into careful consideration in planning and carrying out daily schedules. This requires broad understanding and skill in working with children.

The admission process is extremely important. A good day-care program must have attached to it the kind of skillful counseling service that will help families at the point of intake to reach the correct solution in selecting day care or making some other choice for themselves and for their children.

Good day-care programs are conducted in rooms that are well-ventilated, well-lit, and above street level. Outdoor space as well as indoor space is

large enough for active play and equipment is plentiful, readily accessible, and carefully selected to provide the tools a teacher needs to help children learn and to give them an opportunity to develop intellectually and physically as well as emotionally. Staff trained in handling children are present at all times. Children from 3 to 6 are served in groups, each having a teacher who is an expert in the field of early childhood education. The groups of preschool children are small enough to allow a relationship to be established between the teacher and the individual child. For instance, groups of 3-year-old children have no more than 15 children to a teacher and assistant. Two-year-olds are in family day care and not in group programs.

These are some of the standards for day-care programs recommended by the Child Welfare League of America.[1] Unfortunately, however, they can at the present time be properly classified only as goals, for few centers have reached them.

Good day care is expensive. It may cost as much as $1,000 a year per child. It is, of course, not as costly as full-time congregate care, residential treatment for emotionally disturbed children, mental institutions, correctional care or even public assistance.

Bad day care on the other hand can be as damaging as the absence of care. Its presence lulls us into believing that the child is being safeguarded when actually intellectual and even physical destruction may be taking place.

The Need

Considering the cost of good day-care programs, the need must be great if public financing or administration is expected to be involved. Unfortunately, we have very little accurate information on the full extent of need. We do know, however, that when a day-care center is established in an area accessible to low-income housing, and when the fees are within the reach of nearby families, authenticated waiting lists run high. We also have strong reason to believe that where no services exist, families are making poor or even dangerous arrangements for their children. We find documentations of this in the newspaper stories of family catastrophes, as when a house catches fire and young children are found at home alone—or we find this in the numbers of unsupervised young children whom we see playing on our city streets, in migrant farm camps, or in military installations.

These are visible, if unscientific, evidences of what seem to be rather widespread neglect of young children. But we also have some startling figures collected 3 years ago by the Bureau of the Census for the Children's Bureau,[2] in an effort to find out what was happening to the 5 million children under 12 whose mothers were working full time. Based on a sample one-day survey, these figures indicate that 1 out of every 13—or more than 400,000 children—were left to fend for themselves while their mothers were at work. Of the children who were not left entirely on their own, 558,000 were cared for in their own homes by relatives under 18; and 647,000 were cared for through arrangements other than through regular mother-substitutes or group care. Such arrangements ranged from working with the parents chopping cotton in the fields to haphazard shifting of the child among various relatives. The largest percentage of children caring for themselves came from farm areas where it is often assumed that day-care services are unnecessary.

Figures from the Bureau of the Census, obtained in a 1959 survey, indicate that 14,700,000 children under 18 in the United States had mothers who were employed either full or part time.[3] Nearly one-fourth of those who are in husband-wife families had mothers who were employed; while almost half the 5½ million children who lived with their mothers only—including 621,000 children under 6—had mothers who were employed. Of the working mothers in these one-parent families, 44 percent had incomes under $2,000 a year; an additional 39 percent had incomes between $2,000 and $4,000 a year.

Trends in the employment of women offer little promise of a decrease in the number of mothers in the labor force in the foreseeable future. In March 1958 there were 80 percent more women with children under 18 in the labor force than there were in 1948. In 1890, married women constituted 13.5 percent of the number of women who were working; in 1959, they constituted 55 percent. At the end of World War II, Federal aid for day care was discontinued because it was confidently expected that women would return from defense industries to their homes. Yet there are 3,700,000 more married women in the labor force today than in March 1950.[4] We must face the fact that our economy now depends largely on women workers.

Many aspects of our culture add inducements to women to work—including such pressures as status and its relation to material possessions, the contempt with which large elements in our society view recipients of public assistance and the bare subsistence levels of the aid-to-dependent-children

grants. The high incidence of separation and divorce and the rise in illegitimacy, resulting in a large number of families with only one parent, are also factors that are moving women into the labor field. These also create a need for day care even if the mother is not working. Children from homes where there is only one parent may have a desperate need for day care, to compensate for a distorted family picture. In March 1960, there were 5,727,000 one-parent families in the United States.[3]

In spite of fears to the contrary, evidence indicates that the presence of good day-care services does *not* act as an incentive for a woman to go to work; it merely relieves her mind about the kind of care her child is getting. A study of womanpower by Columbia University a few years ago [5] found no correlation between the existence of day-care programs and the number of women in the labor force in any locality.

Some Advantages

There are innumerable instances where a child's ability to withstand a difficult home environment can be considerably enhanced by day care. For example, mental illness in the family, especially of a parent, can be devastating in its effects on the young child. Day care for the child may be an extremely important aid to the parent's recovery after discharge from the hospital as well as an aid to the child in his relation with the parent.

Day-care programs are also needed for families in which a mother who has been denied warmth and affection in her own childhood has no inner resource for meeting the emotional needs of her child. Unless we can provide for some of these needs during early childhood, we may be perpetuating such a pattern in future generations. If we can give a child the strength to cope with a less than ideal situation without removing him entirely from his family, we have achieved the goal of strengthening family life.

Poor or overcrowded housing often makes it desirable for a child to be absent from the home during the day. The possibility that we will be able to eliminate overcrowding in our city slums, even with the most ambitious of building programs, is a very slim one. Even in our modern housing projects, space for large families has been limited to a point where at times the stability of the family can only be preserved by relieving the mother of the care of one or two children during a major part of the day.

When a child has no room to play, to run, to climb, when he is constantly underfoot, when he is denied the space and freedom he should have, his development may be retarded, his behavior may become destructive, and the tensions in the family may rise in a spiral of irritation and counter-irritation.

The mobility of families today poses additional problems for family life. Children of newcomers to a community, especially those with different cultural backgrounds, may be helped to fit into a resistant neighborhood through the use of day-care services. Cultural integration must begin early if hurt and hostility are to be prevented.

Day-care services are needed for children with such handicaps as mental retardation, blindness, cerebral palsy, heart conditions, deafness, and emotional disturbance. Some specialized centers have accomplished near miracles in helping such children overcome the social handicaps of their conditions. In addition, skilled teachers in a number of regular day-care centers have been able to help less severely handicapped children to participate in a normal program.

One age group, often ignored by planners of day-care programs, requires more attention. A large number of mothers go to work when their children enter school, and many of these children are expected to shift for themselves after school until their mothers return from work. Known as the latch-key group because so many of them wear their door keys on strings around their necks, these children are expected to be self-sufficient in environments that offer a perfect banquet of dangers—from the matchbox on the kitchen stove to the delinquent gang of older boys who hang around on the streets.

Making music is an absorbing activity in this day-care center.

Infants are the most susceptible of all groups to a lack of consistent, loving care from a familiar figure. Yet today many infants are boarded out with neighbors with a surprising degree of casualness. Their mothers are apparently going to work whether or not reliable day-care services are available in the community. If these infants cannot be at home with their mothers or a mother-substitute, it is to society's own interest to make available the kind of service, such as daytime foster family care, which can provide them with the emotional nutrients for healthy growth, without which their personalities in later life could become seriously distorted.

This then is the catalogue of need, and it can be summarized by one phrase: *the neglected child*—the child for whom, during the day, no adult is responsible, or who is left in the hands of an adult who is neither competent, concerned, or able to provide the warm relationship or opportunity for growth that every child needs.

The Public Responsibility

What then is the responsibility of public welfare agencies? As has been pointed out by New York City's Commissioner of Welfare, James Dumpson, there is need for refocusing public welfare structure from a money giving organization to a service-oriented organization for families whose needs reflect the inadequacies of our economic, social, and moral life, and for public welfare then to develop, in cooperation with voluntary agencies, a spectrum of services in sufficient quantity and quality to assure that the welfare needs of every individual can be met in accordance with the highest standards known.[6]

The family counselor or caseworker, working within this broad spectrum, must be able to help families decide what kind of day-care arrangement—whether at home with a parent or away from home—is best for their child. To make a wise choice possible, day-care services must be available.

The public welfare agency, however, must broaden its horizons. The artificial divisions existing between education, health, and welfare services have handicapped all of us who have been working to provide programs designed to use the skills of many professional disciplines and to meet the more encompassing needs of our complex society. We need a new word to take the place of "interdisciplinary," since this too often implies an artificial bringing together of skills instead of the development of a whole program. We are too often so torn by the various perspectives of the different disciplines that we twist programs to conform to departments and organizations instead of developing them to fit the problems of the people needing service. Despite the enormous growth of various kinds of voluntary and public programs, opportunities to serve are still lost in debate about responsibility. The public welfare department must be able to integrate programs with health and education aspects just as education and health departments must incorporate welfare standards.

Our concept of the role of public welfare has changed dramatically in the past 30 years. In the early thirties, when apples being sold on street corners were supposed to keep the wolf from the doors of the unemployed, there were day-care programs in almost all parts of the country. But the concept of public responsibility for them—either in setting up standards for licensing or for helping to defray the cost—was not even a glimmer in the eyes of the social planners of the day. Before the mid-thirties those day-care services which existed were provided almost entirely by private philanthropy or commercial operators without the safeguards of Government licensing. In many instances they offered only bleak custodial care, often in physically hazardous conditions. (I wish it were possible to state that such poor quality services no longer exist.)

The first large-scale public program of day care came in 1936 with the WPA, the Federal work-relief program which expired with the coming of World War II. The major purpose of this program, however, was to provide jobs for teachers, child care being only a byproduct. When the WPA program was liquidated, the Federal Government remained in the picture through a program of grants for local day-care services under the Lanham Act (War Area Child Care Act). These funds were administered through State departments of welfare and by State departments of education, but many of the services were provided by voluntary agencies on a lease arrangement. Again, the program was not provided for the sole purpose of strengthening family life, but also to make it possible for women to go into war industries. Standards of quality were regarded as important, however.

Today's concepts of the role of a public welfare department are as legion as the people and places in our country. In some areas there are misty-eyed nostalgics who would be pleased to bring back the world of the 1890's—while of course retaining television, jet travel, and cellophane. In others, there are the visionaries who would like to establish a

State in which all health and welfare services are provided by "Big Brother." Somewhere in between is a conception under which day care becomes an essential but carefully defined responsibility of government.

Day care may be helpful as an adjunct to a great many family services including public assistance. In some instances, it may be important to help a mother go to work to break a pattern of dependency.

Always keeping in mind that a long day away from home is not the most desirable solution for most small children and that the use of day care requires careful planning, we can still find many instances of families that have been strengthened through a well-planned day-care program. We have in this country been slow in accepting this fact. This is in part due to our unwillingness to realize that there are many homes where mothers are unable to give their children the affection they themselves never received as children, in part to our longing for the past when mother was in the kitchen, and in part to our unwillingness to accept the heavy expenses inherent in providing good day care. The perpetuation of the problems caused by neglect are more expensive than the most costly welfare service.

Financing

Private funds are not sufficient to make good day-care services available at fees that are reasonable enough so that the most needy consumers can afford them. Public funds are necessary for this. Unfortunately, today, public funds for day care are rare. New York City, the State of California, the city of Philadelphia, and a few other places make such funds available for local day-care services. In no instance are they sufficient to provide service to all the children needing it. Some State welfare departments are considering purchasing day-care services from voluntary organizations. The bulk of financial support, however, comes from the overloaded community chests and has been insufficient to meet the day-care needs. Federal, State, and municipal funds, and whatever private resources can be mustered all become necessary.

In addition to helping to finance community day-care services, State or municipal agencies must be charged with the responsibility for enforcement of standards for all day-care services, whether tax-supported, philanthropic, or commercial, to protect children from abuse, neglect, and danger. According to a study made by the Children's Bureau, only 33 States have laws requiring that day-care centers and family day-care homes be licensed.[7]

Where day-care programs do not exist under appropriate auspices, where they are not adequately financed or carefully supervised, where the fees are too high or the centers are not available to low income families, there are usually two alternatives for families who cannot provide care during the day: (1) to give up their children to 24-hour care away from home; or (2) to make arrangements which may result in neglect or even danger for the child, and in guilt and tension for the family. The tragedy of this is that the community too often is not aware of the neglect or danger until disaster strikes.

Those of us who have worked closely with day-care centers have a continuous goal—we hope someday that for every child in every community in this country there will be at least one adult who will have an answer at all times to the question, "Where is the child?" We hope too that whatever the kind of family a child may have, a day-care service will be available for him if he needs one to help strengthen his relationship with his family and to help his family provide something a little closer to our concept of a real home for him.

In working with other agencies—whether oriented to health, education, or welfare, on a national, State, or local level, whether supported by tax or voluntary funds—to achieve this goal, public welfare agencies will be helping to achieve what is basically the goal of all service programs: the strengthening of family life and therefore the strengthening of our kind of society.

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[1] Child Welfare League of America: Child Welfare League of America standards for day care service. New York. 1960.

[2] Lajewski, Henry C.: Child care arrangements of full-time working mothers. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 378. 1959.

[3] Bureau of the Census, Department of Commerce: Current population reports, Series P20, No. 112. December 20, 1961.

[4] Bureau of Labor Statistics, Department of Labor: Marital and family characteristics of workers, March 1960. Special labor force report No. 13. April 1961.

[5] National Manpower Council, Columbia University: Womanpower. Columbia University Press, New York. 1957.

[6] Dumpson, James: Public and voluntary agency partnership responsibilities. Paper presented at the New York State Welfare Conference, Buffalo, October 30, 1961.

[7] Low, Seth: Licensed day care facilities for children; report of a national survey of departments of State Governments responsible for licensing day care facilities. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962.

Five studies in California reveal some . . .

DETERRENTS TO PRENATAL CARE

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THE ASSOCIATION of adequacy of prenatal care to outcome of pregnancy has been well established by studies which have shown significant statistical association between lack of prenatal care and prematurity [1] and infant mortality.[2, 3] But why, in a State with widespread clinical services, should any expectant mother fail to have sufficient prenatal care?

This question has been bothering public health authorities in California during the past decade and, as a result, a number of studies of the extent of and deterrents to prenatal care have been made under various auspices in a number of counties.

In California, the 58 counties are the strongest units of local government, with considerable autonomy and control—jealously guarded by the county boards of supervisors—in regard to public health and welfare policies and the administration of county hospitals. While city health departments exist in some highly developed urban areas, there are no city hospitals or city welfare departments. While all counties do not have county health departments or county hospitals, those that do not have them make other contractual arrangements with community hospitals for the provision of appropriate hospital services, including maternity care.

Of the five studies of prenatal care to be described here, one was made by a county health department and county hospital, one by a county hospital, two by a city health department and a county hospital, and one by the State health department with the cooperation of the county health departments. All of them found that a considerable portion of women of lower income groups were either not getting any prenatal care at all or were not getting care as early as the medical profession deems necessary.

The State health department first called attention to the need for such studies in 1952 when it sponsored two working conferences of State and county public health personnel to consider ways of preventing prematurity. The State did not complete its survey, begun in 1954, until 1956, and by this time several local health agencies were already conducting their own studies. With the exception of the statewide survey, all of these studies were concerned with the coverage of prenatal care rather than with its quality.

One of the first of these local studies was carried out in Alameda County by the local health department's bureau of maternal and child health.[4] This was focused on finding out what happens to expectant mothers who are ineligible for county hospital clinic care, and yet cannot afford private care.

Cooperating in the study were representatives from three local health jurisdictions within the county, from the county hospital, and from the county medical society. For the 6-month period from March 1 to August 31, 1953, a survey of 134 patients ineligible for county hospital outpatient prenatal care was conducted involving a complete followup of 123 of them by public health nurses through the 6-week postpartum period. All 134 ineligible women had been referred by the intake workers of the county hospital to appropriate local health departments within Alameda County, but information on 11 was not available at the time of followup. While information obtained during the home visits constituted the basis of the survey, some

additional information was obtained from the birth and fetal death certificates.

The data show that most of these women were ineligible for county prenatal care on the basis of too much income or lack of residence; 59 percent were not eligible because of their income; 13.5 percent because they lacked the required length of residence in the county; and 14.2 percent for a combination of these two reasons. Of the 123 patients, more than half (66) had received either inadequate or no prenatal care. Inadequate care was considered to be care begun after the second trimester. Of 106 patients who ultimately obtained some prenatal supervision, either through private or semi-private sources or eventually at the county hospital clinic, half were delivered as emergencies at the county hospital.

This suggests that patients who were ineligible for county care and referred to other medical care resources do not, in the final analysis, obtain sufficient care. Knowing that under the law the county hospital has to accept them if they come to delivery as emergencies, many of the women make no other arrangements for care.

In Los Angeles

In connection with an inquiry into the eligibility of its obstetric patients, the Los Angeles County General Hospital briefly reviewed the prenatal care histories of all women who gave birth there during one week in April 1954 and found that one-third had received no such care.[5] Since prenatal care was being offered in 32 health department clinics in the Los Angeles area for women financially eligible under the standards of the Los Angeles County Department of Charities, the State Department of Public Health was interested in knowing why care was not obtained. Therefore, a social work consultant on the State staff interviewed 413 mothers about two days after delivery to find out how much prenatal care they had received and why certain mothers had received little or none. These interviews took place from mid-February to mid-May 1956. Each mother was asked to give information about race, marital status, education, and the amount of prenatal care received. Each mother who had gone to a doctor or clinic no more than once, or not at all, and one-third of the mothers who had gone more than once—199 mothers in all—were asked a further series of questions geared to reveal their attitudes toward prenatal care. Those who had not seen a physician were asked why not.

Some of the highlights from the summary of this study were: 51 of the 413 mothers interviewed, or 12 percent, had not been to a doctor or clinic for prenatal care during the current pregnancy; 39, or 9 percent, had made only one visit. Of those who had had some prenatal care, one-third began care in the first trimester of pregnancy, and about one-fourth waited until the third trimester; 65 percent who had received care had attended a health department clinic, and 16 percent had visited both clinic and private doctor. There appeared to be no difference in classifications according to ethnic groups, residence, or marital or employment status as to number of prenatal visits made or the time prenatal care was begun. The mothers who did not get prenatal care consisted largely of the less educated, the older aged, the users of public transportation, and women who lacked prenatal care in a previous pregnancy.

Among the 51 mothers who had had no care, four were having their first child; 22 had had no care during a previous pregnancy; and 9, some of whom had had several pregnancies, never had care in any pregnancy. Three-fourths of the mothers who had had no prenatal care were delivered previously at the Los Angeles County General Hospital. Of the 21 percent (90) who had no care or not more than one visit, 52 said there were times during pregnancy they would like to have seen a doctor.

Responses of the 199 mothers to the attitudinal questions indicated over three-fourths of the mothers who received care were pleased with it. Over half had no criticisms of the care they had received; one-fourth made some qualifying comments. One-fourth did not respond to the question. In this group, attendance at a prenatal clinic appeared to be influenced adversely by a low educational level, language problems, employment, and problems of caring for other children.

In her report of this study, the social work consultant pointed out that her observations underscored the importance of the prenatal clinic's first contact with the expectant mother. She also reported that the fact that the pregnant woman had a medical problem or was worried about the impending birth did not always motivate her to seek care.

High Risk Groups

Another survey of prenatal care was done in the San José city health department.[6] This survey was carried out by a social worker at the University of California School of Social Welfare, Berkeley, as part of her training in a project sponsored by the

Bureau of Public Health Social Work, California Department of Public Health. Briefly, it sought to determine the reasons why 435 of the 3,948 San José residents who gave birth to live babies during 1958 had had no prenatal care or had deferred seeking care until the third trimester of pregnancy. These mothers were found more often to be teenagers having their first babies, grand multiparas (women who had already had 4 or more children), and mothers over 40 years of age.

Social Factors

The study attempted also to determine whether a relationship existed between the trimester in which prenatal care was begun and such social factors as established residence, knowledge of resources, educational level, religion, and ethnic group. A sample of 30 mothers were selected for individual interview.

Among the women in this sample, the average length of San José residence was 11 years, the average educational achievement was ninth grade, and the average family income was $3,100 per year. Their housing was for the most part "adequate to meet family needs" but few were equipped with telephone, radio, or TV. Most of the husbands were unskilled seasonal laborers. Two-thirds of the women in the sample belonged to minority groups. Over half were of Mexican origin, a cultural group not accustomed to seeking early prenatal care.

Of the 30 mothers interviewed, 4 had had no prenatal care; 5 were ineligible for service at the county hospital, but later were admitted for delivery as emergencies. Three mothers said they did not know they were pregnant until late in pregnancy; 2 said they had not wanted to go for care but gave no reason; 10 said they had no one to care for other children while they were gone; 5 said they saw no reason to go for care since they were not sick; 5 said they put the beginning of care off to save money for delivery by a private physician. All expressed satisfaction with their hospitalization.

Of these 30 mothers, 5 were receiving public assistance through the aid-to-dependent-children program; but the 25 others had had no social agency contact. Twenty of the mothers had contacted both the health department and county hospital in seeking obstetrical care. Except for 3, all were markedly dissatisfied with the hospital's prenatal clinic. Their complaints in the order of frequency were: (1) "Social workers don't talk nice to you"; (2) "Can't see a doctor right away"; (3) "Wait in the clinic is too long"; and (4) "Too hard to get there by bus by 8 o'clock when you have to get someone to stay with the children."

The survey concluded that the financial factor seemed to deter the majority of these mothers from getting prenatal care. While they were ineligible for such care from the county hospital they had inadequate funds for obtaining private care. Of the 20 mothers who had delivered at the county hospital, 15 were billed and were trying to work out arrangements to pay. This problem, the social worker suggested, might deter these mothers from seeking early care in future pregnancies.

A second important deterrent was the problem of finding someone to stay with younger children. Other deterring factors were chiefly emotional or related to poor understanding: fear of doctors; not knowing of pregnancy; dislike of the clinic; or deeming prenatal care to be unnecessary.

Briefly, the major deterrents observed in this study were a combination of external obstacles, inadequate perception of what prenatal care involves, and dissatisfaction with the clinic's procedures. The social worker who carried out the study suggested that it might be easier to minimize the external obstacles—for example, by liberalizing intake policies at county hospitals with respect to residence and financial eligibility—than to overcome the attitudinal deterrents. She pointed to the need for greater efforts by health departments and medical societies to publicize the importance of health supervision for the three high risk groups; and added that identifying the grand multiparas and pregnant women over 40 is not so difficult as finding the pregnant teenager, usually primipara and therefore without a prior health department contact. Once these expectant mothers are located, the social worker suggested, more time and effort with each by the clinic staff to determine her perceptions of care and to overcome obstacles might be effective.

A Wider Study

In 1958, the Los Angeles City Health Department conducted a survey to determine the extent of prenatal care among County hospital maternity patients and "to identify the geographical areas and sociocultural groups where unmet needs are greatest."[7] Nearly one-fifth of all city resident births in 1958 occurred at Los Angeles County Hospital.

The motivating factors for this survey were: The hospital's perinatal mortality rate was 60 percent higher than the rate in the rest of the county. Furthermore, the infant mortality rate for nonwhites,

who are predominant among county hospital patients, had risen steadily since 1954.

The survey was based on a sample of 928 residents of the city of Los Angeles who gave birth at Los Angeles County Hospital or at the University of California Los Angeles Hospital as nonpaying patients. It was conducted by public health nurses located at 16 health centers throughout the city. The nurses completed questionnaires in the course of routine postnatal visits to the maternity patients.

The study revealed that 7 out of 10 county hospital maternity patients had received insufficient prenatal attention, and 2 out of 10 had received no prenatal care at all. For the purpose of study prenatal care was defined as "adequate" if the first visit took place in the fourth month of pregnancy or earlier, and if at least five visits to the doctor or clinic had been made. While the city health department had provided some prenatal care to nearly 60 percent of the patients, most of them had sought care late in pregnancy or had made less than 5 visits for prenatal attention. The least amount of care was received by women with Spanish surnames—a reflection, perhaps of the cultural attitudes of Mexican women toward prenatal care.

As in the 1956 study, the proportion of maternity patients under 20 at the county hospital was greater than for the State as a whole. The data also suggested that many mothers who had adequate prenatal care during their first pregnancy did not obtain it during subsequent pregnancies.

The fact that a woman was married and living with her husband seemed to be a significant motivating factor for seeking prenatal care, since mothers who were not with their husbands had on the whole received less prenatal attention. Established Los Angeles residence, though not a requirement for receiving prenatal care in the local health department clinics, seemed to be a factor influencing the receipt of care, since those patients who had been in the county less than a year had had less care than those who had been there longer. Three out of 10 of the women who had received less than adequate care had not reached high school. Patients with high school or college education were apt to have received more care. However, mothers who had had a junior high school education had received less care on the whole than those who had had only elementary education—a finding for which no reason could be determined.

The public health nurses had identified factors that seemed to be the obstacles to adequate care. Among these were the mothers' attitudes: 25 percent of the mothers who had made fewer than 5 prenatal visits for care said they did not feel prenatal care was important; 19 percent had said they did not know about the free clinics. There were also external obstacles: 25 percent cited care of children and 10 percent cited employment as reasons they had not gone for care more often; 34 percent named a variety of other obstacles too vague to be categorized. The nurses who conducted this study expressed the opinion that some reasons for not seeking care cited by the mothers were closer to being rationalizations of their behavior rather than real obstacles which could not have been overcome by greater motivation.

The social worker who carried out the San José study expressed a similar opinion. She believed that if the mothers had thought prenatal care to be really important, the external obstacles to their securing care might have been surmounted. In the San José sample, only 10 percent of the mothers said they understood why care was important.

The report on this Los Angeles study suggests that "no single attack on the problem of inadequate care is likely to yield a solution. An approach on a wide variety of fronts will be required." However, it points out that the high rate of inadequacy of care revealed by the survey indicates "that existing programs and education techniques are not successful in motivating mothers to obtain adequate prenatal care."

The Statewide Study

One of every eight newborns in California is delivered in a county hospital. At the time when the State department of health was first contemplating its statewide survey of the prenatal care received by obstetrical patients in county hospitals, these hospitals were showing prematurity rates that were 50 percent higher that the rates in private hospitals, infant mortality rates that were 60 percent higher, and maternal death rates that were 200 percent higher. The added costs to the counties for the care of premature infants were estimated at $3½ million a year, exclusive of the social costs. These facts were behind the concern which prompted the 1954–56 survey. In this survey an attempt was made to find out something about the quality of care as well as about the quantity of prenatal attention the mothers were receiving.

The data were collected through personal visits by a physician and a social worker from the State health department to every local health department, county hospital, and local welfare department

having a medical care program. Information was obtained from a total of 93 prenatal clinics.

The net result of the study was the documentation of three major unsolved problems: the inadequacy of the quality of prenatal care received by the patients of county hospitals; the obstacle of eligibility requirements for prenatal care; and the failure of many expectant mothers to seek prenatal care.

The actual quantity of prenatal attention which the mothers had received could not be determined since many of the clinics had no such information. However, the county hospitals estimated that 10 to 40 percent of their obstetrical patients had had no prenatal care. The quality of care was also difficult to measure, since at that time there were no State standards for prenatal care. A few minimum criteria were used to measure quality, however, including the number and kind of professional staff present in the prenatal clinics; the amount of time allowed for the doctors and nurses to discuss patients together; the clinical procedures used; and the degree of restrictiveness in eligibility policies.

The survey revealed that clinic physicians spent from 3 to 45 minutes with the patients per visit. Often the patients were seen only by interns, resident physicians, or general practitioners, with little supervision from obstetricians being provided. The clinic nurses spent from 2 to 41 minutes per visit. In some counties, public health nurses also visited each mother at home at least once during the pregnancy. Nutritionists participated in the prenatal program regularly in 5 counties and provided consultation in 18. Social workers—training unspecified—regularly participated in 17 counties and were available as consultants in 9 others.

The procedures for medical examinations, laboratory tests and the like varied among the counties although those regarded by the State staff as most important had been carried out at least once on all patients. Written nursing manuals on clinic policies were available in 15 hospitals and 7 health departments. Special nutritional advice was given in 31 hospitals and 8 health departments.

Rules in regard to eligibility for care varied considerably, and were available in writing in only 60 percent of the agencies having them. Variations in residence requirements were great. Some counties adhered to them strictly and others gave greater attention to the patient's need for care and to the likelihood of the delivery occurring at the county hospital.

Among the disqualifying factors for free prenatal or obstetrical care were: coverage by health insurance; failure to waive the Statute of Limitations in regard to future suits for payment for medical care (2); failure to accept a lien on property (13); seeking care too early or too late (6); being a primipara (5); income over a fixed amount (3); and failure to provide blood for the hospital bank (1). Eligibility factors related to financial need also varied. In 42 percent of the agencies, budgetary standards used were the same as in the aid-to-dependent-children program; 58 percent obtained no prior medical diagnosis before eligibility determination so that complications or other diseases requiring special care were not taken into account.

Followup

The findings of this first overall study of prenatal care in California led the California State Advisory Committee on Maternal and Child Health to make the following recommendations:

1. That the State Department of Public Health . . . develop standards and recommendations for good prenatal care, and provide consultant teams to local agencies seeking to improve their services.

2. That all eligibility policies be written and be made known to all community agencies and professional personnel who serve these families, and that consideration be given to the development of statewide basic policies of eligibility for prenatal care and for hospitalization for complications of pregnancy. Statewide policies are still being worked on.

3. That local health departments find out, if they do not already know, the extent of the deficit in prenatal care in their communities and the reasons why certain mothers either do not seek or do not obtain adequate care, and use the facts to plan appropriate improvement of local prenatal care.

The State health department has already carried out the first of these recommendations with the publication of a booklet entitled "Standards and Recommendations for Public Prenatal Care."[8] The introduction of this booklet points out that these standards while directed to county hospitals and clinics "may also be helpful to physicians in private practice and to staff of non-tax supported prenatal care facilities." They are presented as minimum standards only.

In addition to spelling out approved medical procedures, these standards take into account the social aspects of good prenatal care, emphasizing the family-centered approach to the patient. They included not only a recommendation that a socioeconomic history be part of each medical history, but also a plan for counseling which emphasizes the need to have certain things explained to the expectant mother on her first visit to the doctor. This suggests that as a minimum, "Every expectant

mother needs an opportunity to discuss the effects of her pregnancy on herself and her family." The booklet also describes the functions and responsibilities of each member of the prenatal care staff.

The California State Department of Public Health is continuing to study problems related to prenatal care, especially in relation to prematurity. In order to understand more fully the types of families having premature births as well as to obtain information regarding other types of perinatal loss, the Bureau of Maternal and Child Health is carrying out a project of matching certificates of births and neonatal deaths, a repetition of a study done in 1949. This will provide data on the socioeconomic and demographic factors in relation to prematurity and maternal complications and what changes, if any, have occurred in these data in the past decade.

The department's Bureau of Maternal and Child Health is also considering a study of the characteristics of Negro families having an infant death. This study proposes to include examination of parental knowledge of facilities and attitudes toward use of medical care. Also under consideration is a study comparing prenatal care and hospital care received by patients of the county hospital and a voluntary hospital in Los Angeles.

The Bureau of Maternal and Child Health is also planning a followup statewide survey to determine what, if any, changes there have been in the quality, quantity, or availability of prenatal care since its 1954–56 study, and to determine the impact on prenatal care as a result of its publication of standards.

Another project in Los Angeles is aimed at the improvement of obstetrical records to provide complete information on prenatal, delivery, and postpartum care, and on the newborn. This is being carried out by the Los Angeles city and county health departments and the county hospital. It is hoped that ways will be found of using the newly developed records to facilitate communications between the health department prenatal clinics and the county hospital. The information should also be useful for research purposes, especially in evaluating various types of patient care.

In Los Angeles also, nurses and health educators are experimenting together with different ways of counseling expectant mothers, individually and in groups.

The California studies described here indicate that many expectant mothers do not get sufficient prenatal care. For the most part, they come from the groups of society which are disadvantaged because of discrimination against minorities, low income, lack of vocational skills, poor education, and undesirable living conditions.

These facts underscore the importance of the maternal and child health program in a total public health program and the necessity of keeping such activities from being thrust into the background by the demands of the newer problems of modern "civilization"—air pollution, radiological hazards, the diseases of aging. Health departments must keep a balance in their programs and try to stimulate the raising of standards at every level of responsibility.

The studies also emphasize the importance of considering the psychosocial and cultural factors affecting expectant mothers in planning a program of prenatal care. Only a beginning has been made toward a look at such internal factors as attitudes, knowledge, and the values put on health maintenance. Information about both external and internal factors must be included if a precise picture is to be obtained of the deterrents to prenatal care.

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[1] Oppenheimer, Ella: Population changes and perinatal mortality. *American Journal of Public Health*, February 1961.

[2] Hunt, Eleanor P.; Chenoweth, Alice D.: Recent trends in infant mortality. *American Journal of Public Health*, February 1961.

[3] Taylor, E. Stuart; Walker, Louise C.: Premature infant deaths. *Obstetrics and Gynecology*, May 1959.

[4] Alameda County Health Department: Prenatal care study, Alameda County. June 1955.

[5] California Department of Public Health, Bureau of Maternal and Child Health: Study of prenatal care in Los Angeles County General Hospital.

[6] Broker, Helen N.: Study of failure to obtain early prenatal care, San José resident live births for 1958. Submitted to School of Social Welfare, University of California, Berkeley, and San José City Health Departments, October 1959.

[7] Swayne, James B.; Ross, Irene F.; Edgerly, Raymond H.: Prenatal care of patients delivered at Los Angeles County Hospital. *California's Health*, July 1, 1960.

[8] California Department of Public Health, Berkeley: Standards and recommendations for public prenatal care. July 1960.

. . . I trust we all agree that males contribute about 50 percent to the illegitimacy problem.

Arthur L. Johnson, associate professor of sociology, University of Minnesota, to the 1961 forum of the National Conference on Social Welfare.

CHILDREN FROM 1912 TO 2012

As Seen at the Children's Bureau's 50th Anniversary

"TODAY we seek for new ways by which the National Government, the States, the county, and private groups can function together in providing a better life for our children," said the President of the United States, John F. Kennedy, on April 9 in opening the 50th anniversary celebration of the founding of the Children's Bureau.

The all-day celebration was attended by some 950 persons—staff members, former staff members, and friends of the Bureau from all parts of the country—whose work in promoting the health and welfare of children has brought them into close association with the Bureau's activities. It was sponsored by a 55-member committee of parents and professional persons from various parts of the country, with Mrs. John F. Kennedy as honorary chairman, and Melvin A. Glasser, Dean of University Resources, Brandeis University, as chairman.

The celebration had a two-way look, back to the past to appraise the accomplishments for children in the half century of the Bureau's existence and on to the future and what might be anticipated as the needs and goals for children in the 50 years ahead.

The President referred to dramatic reductions in infant and maternal mortality in the last 50 years and to the pioneering efforts made by the Bureau to stimulate the programs which have helped to bring about such reductions. Pointing out that many of the programs that are now taken for granted were once considered daring and new, he suggested that the Bureau's anniversary offered an appropriate occasion to rededicate ourselves to renewed pioneering for the well-being of children and youth.

There are, said the President, still too many young people who are dropping out of school, too many young children left at home by working parents, too many children not getting proper inoculations, too many epileptic children who cannot attend school, too many children of migrant farmworkers whose needs receive little attention. The Government, said the President, has an obligation to assume a "supporting role" to teachers, church leaders, and parents in helping promote a better life for children.

The President also spoke of the need for fundamental reform in services to dependent children, of the need to bring the problem of mental retardation "out in the open," and of the importance of physical exercise in keeping children fit.

Desperate Decisions

Dr. Brock Chisholm, former director general of the World Health Organization, and Jerome Wiesner, special assistant to the President, also spoke at the morning session, both emphasizing the urgency of stemming the drift toward the atomic catastrophe that could prevent children throughout the world from having any future at all.

The next step for the Children's Bureau, suggested Dr. Chisholm, is to see to the consciences of our children. And he implied that the worst thing that could happen to them would be for them to have consciences like our own. Our own conscience values, he pointed out, stem from the world of our ancestors who for security had to be concerned only with the welfare of their own survival group—the family, the clan, the tribe, the State, the Nation, as the course of history enlarged man's circle of interdependence.

But 15 years ago the conditions for survival changed, Dr. Chisholm said, and the survival group quite suddenly became the human race. Yet we still have conscience values based on small survival groups, he maintained, and when we are frightened or anxious "we feel that the right thing to do is to prepare to kill more people" although we now have the power to kill three times more people than there are.

With a similarly grave emphasis, Dr. Wiesner said that the real problem was to get through the next decade or two—"if we can do this I'm not so concerned about the next 50 years." As we move on into the future the discoveries of science are going to confront us increasingly with problems which have to be faced not by the individual but by society, he said, for such discoveries as atomic fission and the control of genetic characteristics cannot be left in the hands of individuals if the world is to survive.

Pointing out that we are the first generation to hold the veto power over the survival of the human race as well as the first generation with the facilities for arranging for its survival, Dr. Chisholm said that we have many barriers to deal with in making our "desperate decisions." These barriers, he said, are in our own personalities, and we can only hope that there is time to bring up a new generation taught to think for themselves and so become free of our traditional ways of reacting.

Science, Dr. Wiesner said, represents a human means of speeding up human evolution, and as the most important cultural influence in modern life must be understood. While it extends human capabilities to a new dimension with almost endless potential, he said, it challenges the human race to the evolutionary choice of cultural adaptation or meeting the fate of the dinosaur. This will require an emphasis on helping children become fuller, richer, members of society and "an almost impossible revolution in our attitude toward education," he maintained.

Contrasts between the needs and resources of children in the developed countries of the West and in underdeveloped countries were presented at the luncheon session by Dan Q. R. Mulock Houwer, Secretary General of the International Union for Child Welfare. (See pp. 91–97.)

Past and Future

The history of the Bureau was reviewed in the afternoon session through a documentary presentation prepared by Mrs. Randolph Guggenheimer and narrated by Ben Grauer of the National Broadcasting Co. The narration was illustrated by slides and the voices of

Katherine B. Oettinger, the Chief of the Bureau, and past chiefs Katharine F. Lenroot and Dr. Martha M. Eliot, speaking for themselves, and of others reading the words of Lillian Wald and Florence Kelley, who first promoted the idea of a Children's Bureau, President William Howard Taft, who signed the congressional act creating it on April 9, 1912, and the first two chiefs, Julia Lathrop and Grace Abbott.

Secretary of Health, Education, and Welfare Abraham A. Ribicoff, speaking at the dinner session, praised the pioneering accomplishments of the Children's Bureau and emphasized the importance of finding new ways to remedy and prevent new social ills. New approaches, he said, are particularly required in meeting the needs of the children in the 995,000 families receiving aid to dependent children, in combating the problems of juvenile delinquency, and in improving educational opportunities.

"Our children are the investment of the future," said the Secretary. "If they need help they must have it. If they can be provided with opportunities, we must assure them these opportunities. To fail to do so is to flirt with fate—both theirs and ours."

Buell Gallagher, President of the City College of New York, also speaking at the dinner, emphasized the importance of marshaling all resources of imagination and inventiveness of all the professions to meet the needs of the whole child. He stressed four problems needing particular attention: Improvement of education and training for potential school dropouts; radical revision of education in the early years to improve reading and speech; urbanization of farm families who move to the city; building up the professions that serve children and youth.

A full report of the anniversary proceedings is being published by the Children's Bureau. Highlights of the Bureau's history are also obtainable in the March–April 1962 issue of CHILDREN, a special issue in recognition of the anniversary.

BOOK NOTES

PREVENTION OF MENTAL DISORDERS IN CHILDREN: initial explorations. Gerald Caplan, editor. Basic Books, Inc., New York. 1961. 425 pp. $8.50.

Twenty-one specialists in mental health—consisting chiefly of psychiatrists, psychologists, and pediatricians—report on research and programs in the United States that are contributing to "some stable underpinning for preventive psychiatry for children." The scope of this collection of papers, delivered at a 1960 conference in preparation for the Fourth International Congress of Child Psychiatry to be held in Holland in 1962, covers various aspects of organic etiologic factors in emotional disorder, including pregnancy complications, the preventive possibilities of professional intervention in personal and family crises, and the possibilities of preventive work in the "dynamics of teaching."

ADMINISTRATION OF COMMUNITY HEALTH SERVICES. Edited by Eugene A. Confrey. The International City Managers' Association, Chicago, Ill. 1961. 560 pp. $7.50.

Charting guidelines in public health policy and programing, for the benefit of city and county planning and administrative authorities, this volume is the latest in a series of 11 volumes, each on a single aspect of local and municipal administration—with training and reference material—published by the city managers' organization.

The 26 chapters, by administrators and principal aides in community and public health services, outline the essentials of a comprehensive public health program including among other aspects, planning and evaluation, accident prevention and poison control, maternal and child health, health education, nutrition, and health services in disaster.

Prepared in cooperation with the American Public Health Association, the work has copious illustrative material and a bibliography.

EXPERIMENTS IN SURVIVAL. Compiled and edited by Edith Henrich; commentary by Leonard Kriegel. Association for the Aid of Crippled Children, New York. 1961. 199 pp. $3.50.

Thirty-three physically disabled people write about themselves in this book. They communicate their fears, hopes, disappointments, and the problems of learning to function and survive. In short, they tell what it is like to live with a physical handicap.

They are clerks, teachers, students, shopkeepers, whose narratives range from those with narrow focus on the "most crucial of all times—the beginning" to others that illuminate the persistent problems of everyday living. A capsule biography introduces each story and a postscript at the end of the book comments on the importance for the handicapped, the rehabilitation worker, and the public at large to achieve a realistic attitude toward the problems of being physically handicapped—devoid of sentimentality, exploitation, or denial, but with full awareness of the loneliness, pain, and frustration which are the daily diet of the severely handicapped person.

EDUCATING EXPECTANT PARENTS: some observations and recommendations based on a research study. David Mann, Luther E. Woodward, and Nathan Joseph. Visiting Nurse Service of New York, 107 East 70th Street, New York 12. 1961. 224 pp. $4.50.

One of the dominant themes in the authors' observations about classes for expectant parents, based on their 4-year evaluation of those who attended classes given by the Visiting Nurse Service of New York, is this: The course content can be so abstract that these people feel unprepared when faced with the "concrete" issue of baby's crying, refusing to eat, or other displays of negativism. So, the authors advise, instead of teaching what expectant parents say they want to learn—parent educators ought to teach them what "baby" is really like.

HERE AND THERE

Child Refugees

More than 8,000 unaccompanied Cuban children are estimated to have arrived in Miami as refugees from the Castro regime since the end of December 1960, and the influx is continuing at a rate of some 300 a month. Most of these children are adolescents, ranging in age from 12 to 18. Boys outnumber girls, two to one.

A little more than half of these unaccompanied Cuban minors have gone directly to homes of relatives or friends, and the remainder have been placed in children's institutions, boarding schools, and foster family homes in various parts of the country through a program of cooperative voluntary-public effort involving the Federal Government, the Florida State Department of Public Welfare, other State welfare departments, several national voluntary agencies, local child-caring agencies in Miami and vicinity and in other communities where the children have been placed. The national voluntary agencies especially concerned with this program are the National Catholic Welfare Conference, Church World Service, United Hebrew Immigrant Aid Society, and the International Rescue Committee.

The Florida State Department of Public Welfare is serving as the agent of the Department of Health, Education, and Welfare in administering the Federal Government's program for aid to Cuban refugees. (See CHILDREN, May–June 1961, page 116.) As a part of this program the Federal Government pays for foster care for these children on a per diem basis from the child-caring agencies. All arrangements for meeting the children at the Miami airport, for their temporary care before placement, and for selecting the agencies or institutions which will provide care for these children are made by the voluntary agencies. Children have been placed in 67 cities in some 30 States. Besides Miami, cities which have received more than 50 children for placement include: Helena, Mont.; New York, N.Y.; Reno, Nev.; St. Augustine, Fla.; Toledo, Ohio; and Wichita, Kans.

Since 95 percent of the children coming from Cuba are Catholic and nearly all the children in the program arrive in this country at Miami, the main burden of placement has fallen to the Catholic Welfare Bureau of the Diocese of Miami. This agency has arranged for the temporary shelter of nearly 3,000 children in Miami and has placed about 950 children in institutions and foster family homes in Miami and the rest of Dade County. It has also arranged with child-caring agencies elsewhere for the acceptance of Cuban children. To carry out this program the Catholic Welfare Bureau has set up a new unit and five transient centers, the new unit operating separately from the agency's regular child-care program which is supported by the Miami United Fund. The unit for Cuban children has a staff of 325 workers including 21 Spanish speaking priests and members of religious orders, the majority refugees themselves.

Other Miami agencies which have received Cuban children are the Jewish Family and Children's Service and the Children's Service Bureau, a nonsectarian agency.

Since the Federal program of assistance for unaccompanied Cuban refugee children was started, some 4,000 children have been given foster care for varying periods of time. Approximately 1,300 children have already rejoined their parents in the United States or have gone to live with relatives or close family friends. As of January 31, 1962, there were 1,923 in institutional care and 527 in foster family care.

Human Rights

"If Congress takes no further action on this matter next year, I will implement my decision that segregated education off base for children living on Federal property is unsuitable and will proceed under the authority given me in the statutes [Public Law 815, September 23, 1950, as amended, and Public Law 874, September 30, 1950, as amended] and will proceed to provide nonsegregated education for these children," said the Secretary of Health, Education, and Welfare Abraham A. Ribicoff, on March 30, 1962. With the implementation of this decision no child living on Federal property will be required to go to a segregated school after September 1963.

The Federal statute for school assistance in federally affected areas, to which the Secretary referred, provides assistance for the construction of school facilities and for operation of schools for those school districts overburdened with children who live on Federal property or who live with a parent employed on Federal property. Payments are made on a per child basis under a formula written into the law.

. . .

The possibility that the Federal Government may unwittingly be playing a role in the maintenance of patterns of racial segregation was examined at the February meeting of the Interdepartmental Committee on Children and Youth. William L. Taylor, director of the Division of Liaison and Information of the U.S. Commission on Civil Rights presented some of the findings in this regard included in the Commission's five-volume 1961 report. He asserted that while the Federal Government is not directly implicated in segregation, yet, by maintaining a policy of "neutrality" in various of its grant programs related to education, housing, health, and employment, in many instances it was subsidizing discriminatory programs.

In addition to school construction and maintenance in federally affected areas, Federal money through loans and mortgage guarantees is a major force in the expansion of housing and home finance industries, as well as in hospital construction, vocational training, and other grant-in-aid programs where discriminatory practices persist, Mr. Taylor reported.

Mr. Taylor reported that the Commission had made two types of recommendations in this regard: (1) the conditioning of Federal funds to the assurance of nondiscrimination in their use; and (2) affirmative programs of Federal financial support to programs which emphasize action to overcome discrimination.

The five volumes of the Commission's report are: "Voting" ($1.25); "Education" ($1); "Employment" ($1);

"Housing" ($1); "Justice" ($1). They are for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C. A sixth volume, "Civil Rights," includes excerpts from the other five volumes. It is also available, for 45 cents, from the Superintendent of Documents.

Child Welfare

Prompted by reports of apparent increases of the numbers of infants and young children who have been subjected to physical abuse, the Children's Bureau held an all-day conference in Washington in mid-January to discuss ways the Bureau might help States and communities combat the problem. At the conference, which was attended by 25 pediatricians, judges, lawyers, social workers, and other specialists from various parts of the country, numerous incidences were cited of evidence of past injuries being discovered in children brought to hospitals for treatment of an "accidental" injury.

The discussion focused on the complexity of the problem, particularly in determining whether or not abuse actually exists and in taking action to protect the child from further abuse. Because of the difficulty of diagnosis when parents or other caretakers have been involved as well as because of the confidentiality of information relating to their patients, physicians are often reluctant to report suspected abuse to the courts, it was reported. Treatment of the problem, it was agreed, requires the concerted efforts of medical, legal, and social workers.

Among the proposals for Children's Bureau action were the dissemination of information to the various professions dealing with children and the further exploration of the need for legislation.

. . .

By March 1, the deadline for applying for funds under the new Children's Bureau program of research and demonstration grants in child welfare, 63 applications had been received.

The program, authorized by the 86th Congress in 1960, will support demonstration and research projects of national or regional significance and those demonstrating new methods or facilities with promise of contributing to the advancement of the child welfare field. The grants may be made to public or nonprofit institutions of higher learning or public or nonprofit bodies engaged in child welfare research.

Forty-two of the applications fell within the present priorities of the Children's Bureau—social services provided by public and voluntary child welfare agencies, and research that showed promise of contributing to the advancement of these services.

Among the applications were proposals for projects for mentally retarded children, new uses for day-care services—such as raising the cultural level of children and their families that have been culturally deprived—and for homemaker services, study of adoption of foreign children by American parents, followup of older children and their adoptive parents, and demonstrations of social group work for parents and children with special needs and of counseling teenage married couples. Recommendations on grants will be made to the Chief of the Bureau by a nine-member advisory group, meeting on May 15, 1962.

June 1 is the deadline for new applications to be acted on in the fall of 1962.

Mental Retardation

Some 400,000 newborn infants with be screened for phenylketonuria during a year starting July 1, 1962, in a national program spearheaded by the Children's Bureau, to help ward off mental retardation resulting from this disease. With the cooperation of selected hospitals and State health departments, the program will apply the new Guthrie Test, which reportedly can detect babies with phenylketonuria during the first few days of life. A special diet can then be set up to control the disease and prevent mental retardation.

The new test, using a few drops of blood from the baby's heel, was developed by Dr. Robert Guthrie of the University of Buffalo. It has been used in screening more than 3,000 persons for phenylketonuria in New York. Until now, the most widely used test was the ferric chloride, or diaper, test of urine, which cannot be used effectively until several weeks after birth.

If the testing procedures prove widely applicable, they will be extended to programs for other inborn metabolic errors.

. . .

The Hawthorn-Northville Chapter of the Michigan Association for Retarded Children recently purchased a bus for the Children's Service of the Northville State Hospital with the use of trading stamps gathered in a campaign that brought in stamps from all over the State and beyond. The bus will be used to take children to classes at a specialized treatment facility for emotionally disturbed children several miles away.

Nutrition Conference

Some 300 educators, nutritionists, and physicians attended a Nutrition Education Conference in Washington, D.C., the last 3 days of January 1962. The fourth such national conference held since 1941, the meeting was sponsored by the Agricultural Research Service of the U.S. Department of Agriculture and the Interagency Committee on Nutrition Education which is representative of the U.S. Departments of Agriculture, Interior, State, and Health, Education, and Welfare; the American National Red Cross; and the North American Regional Office of the United Nations Food and Agriculture Organization.

In contrast to the 1941 conference, which concentrated chiefly on malnutrition, the conference this year emphasized the social and emotional aspects of food, overnutrition, and obesity. With the theme, "Improving Education for Children," it examined the contributing factors to poor food habits among young people, the possibility of coordinated and comprehensive educational programs to help children achieve and maintain good food habits; and the contribution the conference participants might make to such programs.

The general consensus seemed to be that the diets and nutritional status of children as a whole in this country are today better than ever before in the Nation's history, but that there are still areas of needed improvement. Among the examples of the latter cited were: a lack of calcium and vitamins C and A in some children's diets; a tendency for many teenage girls to decrease their food intake at a time when their need for food increases; a tendency toward overweight among relatively inactive children, encouraged by the ready availability of a variety of food with high sugar content—as in vending machines—and by the high level of purchasing power among children today.

The participants repeatedly urged the application of current scientific knowledge of the behavior patterns of

children and teenagers in an effort to improve food habits. The importance of recognizing the varying nutritional needs of children in various stages of growth and states of health was also stressed, as was the importance of helping children to acquire good food habits early through nutrition education for the parents.

Pointing out the relation of good nutrition to physical fitness, Ruth M. Leverton, assistant administrator of the Agricultural Research Service, suggested that "when our children and youth see physical fitness, including nutritional well-being, related to what they want to do and what they want to be, they will be eager for the information and training that will help them develop good habits of activity and food selection."

Services in Housing

A joint effort to promote services related to health, education, and welfare in public housing projects was initiated in mid-March by the Secretary of Health, Education, and Welfare, Abraham A. Ribicoff, and the Administrator of the Housing and Home Finance Agency, Robert C. Weaver. To implement the program, a 22-member task force representative of various units of the Department and the housing agency has been formed, charged with studying the needs of tenants in low-income housing projects, developing projects toward meeting these needs, and recommending to the Department and the Agency measures to improve services to persons living in public housing.

The task force is directed by Wilbur J. Cohen, Assistant Secretary of Health, Education, and Welfare, and Marie McGuire, Commissioner of the Public Housing Administration. Co-chairmen of the group are Abner Silverman of the Public Housing Administration and Alvin L. Schorr of the Social Security Administration. An advisory panel composed of experts in the variety of services needed by low-income families in urban settings has been appointed to work with the group.

While many of the needed services may be available for residents of low-income housing projects, frequently they are distant from the project or the residents are unaware of them. The task force is undertaking the dual assignment of identifying all of the appropriate services provided through programs of the Department and negotiating with State and local agencies and housing authorities for one or more demonstration projects in which a concentration of services can be made available simultaneously within or near the project site, plus information about them to the project residents.

Such services may include those concerned with aid to the aging, the prevention of juvenile delinquency, job training, day care of children, health, rehabilitation for the disabled, and money management and housekeeping.

Vital Statistics

According to the Public Health Service, a total of 4,257,850 live births were registered in the 50 States during 1960, or 4,000 fewer than in 1959, continuing a 4-year downward trend in the birth rate (23.7 per 1,000 live births as compared with 25 in 1957).

Although 700,000 more babies were born in 1960 than in 1950, the birth rates for the 2 years are almost the same. Named as a contributing factor in this static rate is the 5-percent decline in birth rates during the decade in the South, where the rates traditionally have been high—a drop not offset by higher rates elsewhere.

Alaska reported 33.4 live births per 1,000 population in 1960, the highest figure for any State, while the lowest rate was recorded for West Virginia, with 21.2. The relative position of these States in 1950 was fourth and twenty-second, respectively. Such changes in States' birth rates, the Service attributes to such causes as the immigration of young adults of childbearing ages; the postponement of births in areas of high unemployment; and the effects of previous high birth rates on the population's age composition.

The year 1961 is estimated to have appreciably more births registered than during 1960, but not enough to change the downward trend in the rate.

. . .

Since 1954, the infant mortality rate among American Indians of the United States, except Alaska, dropped 30 percent in 6 years—from 65.5 per 1,000 registered live births to an estimated 46 per 1,000 in 1960. The infant mortality rate for the Nation as a whole was 26.4 per 1,000 live births for 1959 and the provisional rate for 1960 was 25.7. Among Indian babies aged 28 days through 11 months, the fall in the death rate was 41 percent in the period 1954 through 1959. Only about 21 percent of all Indian deaths reported for 1959 were of babies under a year of age compared with 27 percent in 1954.

For Health

Field trials of two types of measles vaccine, of killed virus vaccine alone, and of killed and live virus vaccines in combination, were begun in mid-December 1961, among 5,000 children in five parts of the country—the first large-scale tests of this nature. In cooperation with the Communicable Disease Center of the Public Health Service, local health departments are conducting the trials in Dekalb County, Ga.; Cincinnati, Ohio; Seattle, Wash.; and in Rochester and Buffalo, N.Y. Previous trials of measles vaccine tested the live vaccine alone, frequently producing fever or rash; and the live vaccine used with gamma globulin, supplies of which may be inadequate for mass vaccinations. (See "For Health," CHILDREN, Jan.–Feb. 1962, page 34.)

In the current study, children are being divided into three groups: those receiving three shots of killed virus vaccine; those receiving two shots of killed vaccine and one of live; and those receiving dummy injections.

. . .

Late in 1961, the Public Health Service began a survey of professional but inactive nurses who maintain State registration in order to determine how many of the country's estimated pool of 200,000 such nurses can be called on to return to full or part-time work and under what conditions. The survey results will be made available to communities for use in program planning or expansion.

The first group of questionnaires was sent to inactive nurses in the States of Alabama, Georgia, Kansas, Mississippi, North Carolina, and Vermont, with the cooperation of the State boards of nurse examiners and State nurses associations.

. . .

A new program to promote the application of research knowledge in the field of neurological and sensory disorders has been set up by the Public Health Service. As the Neurological and Sensory Disease Service Program, the new unit will stimulate, develop, and support activities concerned with prevention, diagnosis, and treatment

of such disorders as epilepsy, cerebral palsy, multiple sclerosis, mental retardation, and some types of vision, speech, and hearing defects; and with the rehabilitation of persons affected by these conditions.

The program, administered by the Bureau of State Services, will provide consultation, technical services, demonstrations, training, and health education to communities directly and through grants, in cooperation with State health agencies, medical schools, professional organizations, and other private and public nonprofit groups.

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A task force appointed by the Public Health Service has charted a six-pronged campaign against infectious syphilis, based on findings that show a rise of more than 130 percent in cases of this disease among teenagers between 1956 and 1960. The study group's plan calls for spending $3½ million annually for 10 years over funds currently available to the Service for direct operations and grants to the States for venereal disease control. The recommended steps were these:

- An intensive national effort providing for at least two visits a year by a specialist in venereal disease to the general practitioners across the country and one visit a year to other physicians to help alert doctors to the symptoms of syphilis in their patients.
- A program to insure that all blood processing laboratories report to health departments all specimens with positive reactions to syphilis along with the names of the patients.
- More research in syphilis immunology, therapy, and laboratory procedures and on adolescent and young-adult behavior.
- The broadening of interview investigation services toward covering all infectious syphilis cases.
- A broad education program for professional workers and the general public.
- Continued support of the program by Federal, State, and local governments even after the reported number of cases begins to decline.

Considered particularly disturbing was evidence that syphilis is being spread unknowingly, especially among teenagers. The task force noted the need for further efforts to bring private physicians into the control effort. The members estimated that such physicians now report slightly more than one-half of the syphilis cases they diagnose and treat, compared with only about 25 percent in the 1955–58 period.

The 18,781 cases of syphilis reported for the fiscal year 1961 was the highest total since 1950.

Health Research

With the goal of finding out more about the relationship between virus infection in expectant mothers and neurological disorders—such as cerebral palsy, Mongolism, and mental retardation—in newborn infants, a study involving more than 75,000 pregnant women has been launched by the National Institute of Neurological Diseases and Blindness and the National Institute of Allergy and Infectious Diseases, Public Health Service.

Blood samples collected from expectant mothers at 16 collaborating medical centers throughout the Nation are being tested at the Institutes for evidence of exposure to more than 100 viruses, ranging in severity from common cold viruses to those causing paralysis and death. The tests make use of antigens—substances that stimulate a chemical defense mechanism in the blood. Together with data on the patient's pregnancy, information on her serum sample is to be retained for years.

The study is a phase of a broad NINDB project, started 5½ years ago, in which mothers-to-be are examined from early pregnancy through labor and delivery, and their babies followed up from birth through school age. One goal of the study is to widen understanding of the processes of conception, pregnancy, labor, and delivery as related to growth and development of the child. Another aim is the collection and analysis of data on factors possibly related to disorders of infancy and childhood.

Mental Health

A conference in followup of the report of the Joint Commission on Mental Illness and Health—released in April 1961 under the title, "Action for Mental Health" (Basic Books, New York)—was held March 5–7, 1962, in Washington, D.C., under the sponsorship of the National Association for Mental Health in cooperation with more than a hundred national social, health, civic, and professional organizations.

In the report, the Commission—formed through Congressional action in 1955, of representatives of 36 national organizations—distills the fruit of 6 years of factfinding on the needs and care of the mentally ill and charts lines of action for a national mental health program. Considering the current lag in treatment of the mentally ill as reflecting a basic pattern of social rejection, the report underlines the need for more public understanding of mental health problems and more cooperation between all types of organizations at all levels in developing mental health programs.

Gathering in five study groups, the more than 200 participants focused their discussions on mental health program development from the vantage points of communities and of national organizations, developing such lines of emphasis as these:

- Like any other work in human welfare, the mental health program that does not start with the individual, does not start; and if it ends with him, it ends indeed.
- Education of the public cannot be achieved in a vacuum, but rather through demonstration and confrontation, for example, through the cumulative effect in time, of recruiting an army of volunteer workers when they are young.
- The volunteer can be interpreter between community and patient and link between him and employer.
- We must look for what it is in our society that, although producing fine service programs and dedicated volunteer workers, engenders broken homes, delinquency, and mental illness.

. . .

A research project designed to help strengthen lines of communication and coordination between nursery education and the mental health disciplines has recently been initiated by the Child Development Center of New York, a voluntary clinic with a nursery school which concentrates on the study and treatment of emotionally disturbed children. Under the project a team of nursery educators, social workers, pediatricians, psychologists, and psychiatrists will seek to unify their efforts. Its director is Peter B. Neubauer, M.D.

An early step in the 5-year project will be the cooperative development of criteria for evaluating child develop-

ment. Another will be the determination of what function each discipline has in fostering healthy growth and in detecting and helping the disturbed child.

The project, estimated to cost about $300,000, is being underwritten by the Grant Foundation.

Unmarried Mothers

Broadening the scope of services at child health stations in low-income neighborhoods of New York City to include direct social services to mothers, was foremost among recommendations emerging from a recently reported study of the socioeconomic and medical problems facing young, unmarried mothers registered at such stations in the Central and East Harlem Districts.

Conducted in 1960 by Dr. Nina Bleiberg and three associates from the city's department of health, the study provided a questionnaire that was used by 25 doctors at 10 health stations in interviews with 300 primapara mothers under 22 years of age. Of this group, 116 were unmarried; 80 percent were Negro and 20 percent, Puerto Rican. Among the 206 teenage mothers in the total group, 43 percent were unmarried when interviewed.

The findings indicated that the unmarried mothers were generally inarticulate about expressing their social or emotional problems, but a large majority reported having had concern about social stigma during pregnancy.

The study was used to enrich the educational program for the conference medical staff; one of its recommendations called for broadening this program for medical personnel, so as to stress the presence of socioeconomic and emotional elements within the total health spectrum.

. . .

The Research Division of the Children's Bureau in early February began a review of research and demonstrations relating to unmarried mothers and their children. Directed by the Chief of the Child Life Studies Branch, the review team includes a sociologist and a social caseworker. The purpose is to discover how much tested information we have about unmarried mothers and their children, and about the effectiveness of efforts to help them.

The results of the study, scheduled to end in late June, are expected to furnish the bases for: charting needs and setting up priorities in research and demonstration projects; decisions concerning services, programs, and community efforts; and various publications for lay and professional readers.

Correction

Elizabeth G. Meier, lecturer at the New York School of Social Work, Columbia University, previously was district supervisor with the Division of Child Welfare, State Department of Health and Welfare in Maine and worked in child welfare in Michigan, Connecticut, and New York. She did not serve as district child welfare supervisor in Michigan, Connecticut, and New York, as reported in the biographical note that appeared in the January-February 1962 issue of CHILDREN in connection with her article, "Focused Treatment for Children at Home."

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

SKIPPY AND THE FOURTH R. 24 minutes; sound; black and white or color; purchase or rent.

Portrays the family and church working together to help a second grader to understand the value of honesty in family relationships.

Audience: Parents, teachers, parent education groups related to the church.

Produced by: Jarvis Couillard for the Methodist Television, Radio, and Film Commission.

Distributed by: The Methodist Television, Radio, and Film Commission, 1525 McGavock Street, Nashville, Tenn.

AUDITORY SCREENING FOR INFANTS. 15 minutes; sound; color; purchase or rent.

Shows reactions of infants who are 8 to 10 months old to sound stimuli, in order to encourage the use of the auditory screening technique as part of the routine physical examination of every infant by the time he is 8 or 9 months old.

Audience: Physicians; nurses; speech and hearing specialists; medical and nursing schools; schools of public health; and speech and hearing centers.

Produced by: Child Growth and Development Study, The Johns Hopkins University and the Division of Maternal and Child Health, Maryland State Department of Health.

Distributed by: The Bureau of Preventive Medicine, Maryland State Department of Health, 301 West Preston Street, Baltimore 1.

THE WELL CHILD CONFERENCE. 14 minutes; sound; color; purchase.

Shows how doctors, nurses, volunteers, and parents can work together to provide health supervision for babies and young children at a well child conference.

Audience: Professional health workers; students; parents.

Produced by: Kent Lane Films for the Kentucky State Department of Health.

Distributed by: Kent Lane Films, care of George W. Colburn Laboratories, 164 North Wacker Drive, Chicago 6, Ill.

A NEW WORLD FOR PETER. 22 minutes; sound; purchase or rent.

Tells in a child's own words about his trip to the hospital, his operation, and the people who helped make him safe and comfortable.

Audience: Parents, teachers, elementary school children or discussion leader: social worker, nurse, or dietitian from the community who is familiar with local hospital practices.

Produced by: Kay Hanna for the Parents' Committee of the Children's Ward of Tompkins County Hospital, Ithaca, N.Y.

Distributed by: A New World for Peter, Post Office Box 23, Ithaca, N.Y.

READERS' EXCHANGE

BAUMGARTNER: ***Parent education needed***

I read with great interest Dr. Leona Baumgartner's article, "A Fresh Look at Child Health." [CHILDREN, March–April 1962.] It is encouraging to be reminded of the progress made in less than 50 years, particularly as the progress is continuing, and it is timely to emphasize that dollars alone do not achieve the goals though they may ease the task if properly utilized. Repeated review and re-evaluation of the problems as well as the facilities and personnel available are essential to maintain progress at the highest rate.

The specialization mentioned by Dr. Baumgartner is not limited to the field of medicine. It has occurred in the fields of social work, welfare, and in education. In fact, I believe that here and there I see physicians broadening their focus to include not only the "whole" individual, but also his social and economic environment. Increasingly the health problems are being met by the team-play Dr. Baumgartner has mentioned. Specialization will continue and should be encouraged to a certain extent. After all it is the result of recognition of a problem and research into the causes and treatment.

The most obvious difficulty in relation to medical education is the mass of material to be studied, evaluated, and appropriately utilized in the continuing education of the physician. Not recognized by many is the impossibility of teaching experience. Experience can only be achieved and sometimes painfully. The controversy in medical education is a healthy one and as long as it exists we are not in danger of becoming stereotyped in our thinking and in educational methods. When one talks to a group of medical students any worry about becoming stereotyped is alleviated. Their attitudes vary in direction and intensity with a high percentage showing a healthy scepticism. We try to give them a good basic knowledge and a determination to learn more.

One area of education and training Dr. Baumgartner did not discuss is much more difficult to teach than medicine: how to teach people to be parents. We can teach parents only general principles which must be interpreted for each individual. Even a knowledge of principles does not mean parents can apply them in the pressure of all the duties, stresses, fears, and confusion with which they must contend, even under the best of circumstances. Some of the labor-saving devices mentioned by Dr. Baumgartner may give more time for this type of education.

Philip S. Barba, M.D.
Philadelphia

ADAMS: ***Defense of study***

Because of my involvement in one of the studies described in Hannah Adams' article entitled "Two Studies of Unmarried Mothers in New York City" [CHILDREN, September-October 1961], I feel compelled to take exception to a statement of Charles E. Bowerman in his comments on the article. ["Readers' Exchange, CHILDREN, January-February 1962, pages 39–40.] Prof. Bowerman says "It is likely that much, if not all, of the differences found between married and unmarried mothers with respect to amount and type of prenatal care, infant mortality, and so on, would have disappeared if the data had been controlled for socioeconomic status, broken-home background, and other variables which might be considered as more basic than the marital status of the mother."

The study of the Community Council of Greater New York, and the study representing a joint project of the health and welfare departments indicate that the differences in the prenatal medical care records of married and unmarried women are greater than could be attributed to socioeconomic differences alone. In the Council's study of deterrents to prenatal care and social services, we point out that "the differences in the timing and regularity of prenatal medical care among the unmarried mothers of various age, ethnic, or religious groups, or education, are not nearly as marked as the difference between all unwed expectant mothers and married expectant mothers."

Although our study indicates that the unwed mothers who have attended college have a better record of prenatal care than those who have not, this difference is small. The analysis of prenatal care in relation to occupation shows that there is little difference in the pattern followed by private household workers on the one hand and women in clerical and kindred occupations on the other. It shows further that operatives and kindred workers have a slightly better record of prenatal medical care than either the private household workers or the clericals. Thus we concluded that except for some of the women who had had some college education, neither education nor occupation appear to be related significantly to the timing and regularity of prenatal care among unwed mothers.

Furthermore, the fact is that the proportion of white unwed mothers who had no medical care at all during the first 6 months of pregnancy was somewhat larger than the proportions of either the Negro or Puerto Rican mothers. Relatively more of the white women had attended college. Relatively fewer of the white women were receiving any form of public assistance and relatively more of the white women were supported, at least in part, by their relatives. It would appear that the urge to conceal the pregnancy, found as a major deterrent to early and regular care of white unwed mothers, counterbalances any influence of socioeconomic status on their use of medical services.

Mignon Sauber
Director of Research, Community Council of Greater New York

BLAKE: ***Example in St. Louis***

It was with much interest that I read Howard Leary's comments on Mary Blake's article in relation to the need for a bible to be put in the hands of youth workers and police working together. [CHILDREN, "Readers' Exchange," January–February 1962, page 39; and "Youth Workers and the Police," September–October 1961.]

In St. Louis we have a plan of close cooperation which has been developed by the city of St. Louis police department and the Youth Project of the Met-

ropolitan Youth Commission, a research and demonstration project on how to work with street-corner youth. The difficult experiences in other cities prompted the commission to develop with our local police department a guide for interagency relationships. Our Commission is very fortunate in having an extremely cooperative, serious, and professionally minded police department interested in a coordinated approach with social agencies in efforts to prevent and control delinquency. Individual copies of the guide have been distributed to all police officers in the district served by the Youth Project.

In St. Louis, our youth workers work with groups only as a means of contact. They aim neither to strengthen the group nor weaken it but to determine the composition of its members, their relationship to each other, and how the group or subgroups within it can be used to keep social behavior under control. There is a misconception on the part of many in various disciplines that group workers are out to organize groups, then lead them as groups. This is a fallacy.

The youth groups our workers are in contact with are for the most part very fluid. The function of the group worker is to see that their members are channeled into social behavior either on an individual or a group basis.

Eugene P. Schwartz
Executive Director, Metropolitan Youth Commission of St. Louis and St. Louis County

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Guides and Reports

MENTAL RETARDATION AND SOCIAL WORK EDUCATION: proceedings of a conference held at Haven Hill Lodge, Milford, Mich., June 16–19, 1959. Edited by Alfred H. Katz. Wayne State University Press, Detroit. 1961. 56 pp. $1.50.

From a conference sponsored by the American Association on Mental Deficiency and the Council on Social Work Education, this pamphlet includes a conference position paper setting forth the responsibility of social work education in the field of mental retardation and stressing the need for a basic understanding among social workers of mental retardation and the importance of the multidisciplinary approach; and three papers discussing: mental retardation as a social problem; social work services to the retarded; and social work education for services to the retarded. Summaries of the discussions are also included.

THE SPECIAL CHILD: diagnosis, treatment, habilitation. Harold Michal-Smith, Shulamith Kasten, and others. New School for the Special Child, Bureau of Publications, 71 Columbia Street, Seattle 4, Wash. 1962. 350 pp. $5.50.

Converging on the problem of training the children having brain injuries, neurological impairments, or functional retardation, from the vantage points of several professions—psychologist, speech pathologist, psychiatrist, and teacher—18 papers in this collection focus successively on mental retardation, brain injury, cerebral palsy, communication disorders, and "nervous habits." They are based on lectures delivered at a 1960 conference in Seattle sponsored by the University of Washington and the New School for the Special Child.

THE HANDICAPPED CHILDREN OF FORT WORTH AND TARRANT COUNTY; a study of community services for handicapped children. Tarrant County Community Council, Life of America Bldg., Fort Worth, Tex. 1961. 106 pp. $1.12.

A report of a study made by a consultant team of three physicians to determine the basic and special needs of physically handicapped children in the area of Fort Worth, Tex. The study was made under the auspices of the Community Council of Fort Worth and Tarrant County, in cooperation with the Texas State Department of Health and the regional medical staff of the Children's Bureau, Department of Health, Education, and Welfare.

WHEN CHILDREN NEED SPECIAL HELP WITH EMOTIONAL PROBLEMS. Greta Mayer and Mary Hoover. Child Study Association of America, 9 East 89th Street, New York 28. 1961. 30 pp. 40 cents. Quantity rates available upon request.

Written for parents and professional persons engaged in services to children, this pamphlet discusses: symptoms of chronically disturbed behavior in children from birth through 17 years; types of treatment available; the professionals engaged in treatment; and the cost and length of treatment.

PHASES OF ADJUSTMENT IN A TYPICAL FOSTER HOME PLACEMENT. Erika Juliusburger. Jewish Child Care Association of New York, 345 Madison Avenue, New York 17. 1961. 20 pp. 75 cents.

A condensation of an original paper given at the 1960 Eastern Regional Conference of the Child Welfare League of America, this report presents the experiences of a 12-year-old girl who for 4½ years lived in the same foster home, describing the phases of adjustment inherent in this type of long-term placement.

PREVENTION - TREATMENT - CONTROL OF JUVENILE DELINQUENCY THROUGH GROUP WORK SERVICES: proceedings of the annual spring conference of the Inservice Training Department, New York City Youth Board. May 1959. New York. 1961. 83 pp. Free.

The conference discussions are abstracted under workshop topics: programing for teenagers; finding the individual in the group; confidentiality and other principles in client-worker relationships; the growing pains of adolescence; and "changing means in changing scenes." The chief concerns to emerge are presented in a summary as community changes, effect of changes on attitudes of youth, and what group workers and agencies can do.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

HEALTH SERVICES FOR MENTALLY RETARDED CHILDREN: a progress report, 1956–60. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 34 pp. 30 cents.

After tracing the development of the Bureau's health services to mentally retarded children, the publication reviews the program's achievements, special demonstration projects, and the work of the Bureau's technical committee on clinical programs. It then projects the future extent and composition of the mental retardation problem, suggesting adaptations of State and local special services and overall program goals.

IMPLICATIONS FOR ELEMENTARY EDUCATION: followup on the 1960 White House Conference on Children and Youth. Office of Education, Department of Health, Education, and Welfare. 1961. 25 cents.

This pamphlet is organized into four sections: (1) "Important Commitments," presenting eight recommendations as an "honor roll of priorities;" (2) "The Good Elementary School," presenting the attributes, curriculum emphasis, general atmosphere, and organization of such a school; (3) "The Operating Context of the School" related to national, community, and family interests; (4) an appendix, presenting an index to the recommendations on education of the 1960 White House Conference on Children and Youth, and recommendations from the 1955 White House Conference on Education.

TRAINING FOR SERVICE IN PUBLIC ASSISTANCE: papers presented at the 1960 seminars for field representatives conducted by the Bureau of Public Assistance, Washington, D.C. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. 1961. 251 pp. $1.

A selection of 14 papers prepared for State field representatives working in the Federal-State public assistance program to help them develop local programs and provide leadership and direction to local welfare agencies. Among the subjects dealt with are policy development, community coordination and planning, administrative methods, interfamily relationships, the needs of working mothers and their children, and implications of the choice to work for mothers in the aid-to-dependent-children program.

DAY CARE SERVICES: form and substance; a report of a conference, November 17–18, 1960. Gertrude L. Hoffman. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 393. 1961. 55 pp. 25 cents.

This is the full report of a conference sponsored by the Children's Bureau and the Women's Bureau of the Department of Labor, in Washington, D.C., and reported briefly in the January–February 1961 issue of CHILDREN [page 35]. Summaries of papers presented at an opening symposium and of the 12 group discussions on the various elements essential to a good community program are followed by the conference recommendations.

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